



Tamlyn Cairns Partnership

HEALTH AND SOCIAL CARE NEEDS ASSESSMENT HMP COLDINGLEY

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Tamlyn Cairns is a trading name for a collaboration between Richard Tamlyn Ltd and Claire Cairns Associates Ltd

List of Abbreviations and Acronyms

Acronym	Definition
AAA	Abdominal Aortic Aneurism
AA	Alcoholics Anonymous
ACCT	Assessment, Care in Custody, and Teamwork
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AGP	Aerosol Generating Procedures
ANP	Advanced Nurse Practitioner
ARC	Analgesic Review Clinic
ASD	Autism Spectrum Disorder
AUDIT	Alcohol Use Disorders Identification Test
BBV	Blood-Borne Virus
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
CHD	Coronary Heart Disease
CNWL	Central and North West London NHS Foundation Trust
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSU	Care and Separation Unit
CVD	Cardiovascular Disease
DBST	Dry Blood Spot Testing
DH	Department of Health
DNA	Did Not Attend
ECG	Electrocardiogram
EMDR	Eye Movement Desensitisation and Reprocessing
EP: IC	Empowering People: Inspiring Change
FAQ	Frequently Asked Question
FIT	Faecal Immunochemical Test
FTE	Full-Time Equivalent
GP	General Practice/Practitioner
GUM	Genitourinary Medicine
HBV	Hepatitis B
HCV	Hepatitis C
HJIP	Health and Justice Indicators of Performance
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
HNA	Health Needs Assessment
HSCNA	Health and Social Care Needs Assessment
IAPT	Improving Access to Psychological Therapy
IMB	Independent Monitoring Board
IP	In-Possession (medication)
ISFL	Incentivised Substance Free Living
KPI	Key Performance Indicator
LD	Learning Disability (also called IDD)
LTC	Long-Term Condition
MAPPA	Multi-Agency Public Protection Arrangements
MECC	Making Every Contact Count
MH	Mental Health
MHA	Mental Health Act
MMR	Measles, Mumps and Rubella
MOJ	Ministry of Justice
MOU	Memorandum of Understanding

Acronym	Definition
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NHSE&I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NIS	National Immunisation Schedule
NMP	Non-Medical Prescriber
NPS/PS	New Psychoactive Substances
NRT	Nicotine Replacement Therapy
OCU	Opiate/Crack User
OFSTED	Office for Standards in Education, Children's Services and Skills
OMU	Offender Management Unit
ONS	Office for National Statistics
OOH	Out-of-Hours
OST	Opioid Substitution Therapy
OT	Occupational Therapy/Therapist
PD	Personality Disorder
PEEP	Personal Emergency Evacuation Plan
PHE	Public Health England
PPO	Prisons and Probation Ombudsman
PTSD	Post-Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
RAG	Red, Amber, Green (rating)
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCPsych	Royal College of Psychiatrists
RECOOP	Resettlement and Care for Older Ex-Offenders and Prisoners
RMN/RNMH	Mental Health Nurse
RSCH	Royal Surrey County Hospital
SMS	Substance Misuse Service
STR	Support Time Recovery Workers
TB	Tuberculosis
TD/IPV	Tetanus, Diphtheria and Polio Vaccination
TTO	To Take Out (medication)

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PART A

Specific Information for HMP Coldingley

Chapter One – Introduction

1.1 Aims

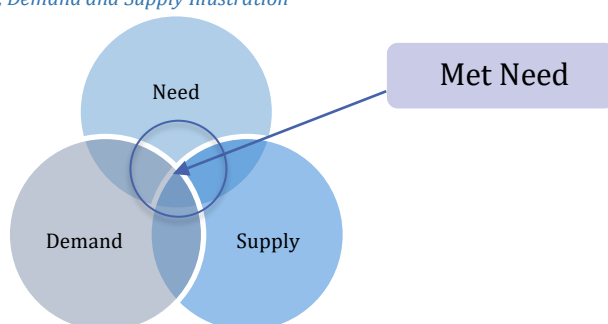
This health and social care needs assessment (HSCNA) was commissioned by NHS England and NHS Improvement (NHSE&I), which is responsible for commissioning prison healthcare, to better understand the health needs of the resident population in HMP Coldingley and to assess the extent to which the current need and demand for health and social care in the prison establishment were being met.

The methodology used for this is the Public Health England (PHE) ‘toolkit’¹ which summarises:

A health needs assessment is a systematic method for reviewing the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce inequalities.²

It should be noted that health needs may be *met* or *unmet*. It should also be noted that there is a difference between a *need* and a *demand* for a service.

Figure 1 – Need, Demand and Supply Illustration



Establishing the extent to which expressed need may be being met is affected by the fall-off between:

1. The existence of a mental or physical health concern
2. The establishment of this need, e.g. assessment/diagnosis
3. The offer of an appropriate intervention
4. The take-up of said intervention
5. The effectiveness and impact of the intervention

There is some data on the above, but not enough to be able to accurately predict most demand. Key points to note though are that not all needs are apparent – including to the person concerned – and that potential service users may not take up available services. The former may be an issue about awareness and screening, the second is often about engagement.

1.2 Scope

As is always the case, there is a fine line between undertaking a health needs assessment (HNA) and a service audit/review. This report focuses on describing the likely and actual

¹ PHE (2014) [Prescribed places of detention: health needs assessment toolkit \(parts 1 and 2\)](#) (accessed Dec 2020).

² Cavanagh, S. and Chadwick, K. (2005) [Health Needs Assessment: A Practical Guide](#) (accessed Dec 2020).

health needs of residents, and the extent to which they appear to be being met, rather than assessing service efficacy, albeit there is a little overlap in places, particularly in the consideration of pathways.

1.3 Covid-19

This report is written during the covid-19 pandemic. The purpose of the report is to predict likely health and social care needs for up to the next three years. No-one is able to project when the pandemic will be brought under control and there is a return to some semblance of 'normal'. This report endeavours to describe need, un-met need, and demand pre covid-19, which is taken as 'normal', then explore the impact of the pandemic and any possible legacy.

1.4 Methodology

The full methodology and rationale are included in an addendum report - Part B.

[Appendix A](#) contains the full list of those interviewed for the HMP Coldingley HSCNA.

Patient (resident) views were gathered in the prison by means of a survey which was distributed across the prison, resulting in 52 completed questionnaires from patients. This equates to 11.4% of the population, based on the operational capacity (op cap) of 456. The survey results can be considered to be representative at a confidence level of 90% and confidence interval of +/-10.8%. We also refer to some of the findings from a recent survey carried out by EP: IC (Empowering People: Inspiring Change) (see [section 3.2.2 Patient Engagement and Consultation](#)).

1.4.1 Comparative

The list of 'comparator prisons' most recently defined by the Ministry of Justice (MOJ) groups establishments by type (e.g. all category C training prisons).³ We have also developed our own database which now has information from previous prison HSCNAs across the country over the last several years. Cross-referencing these two sources, we have selected comparator establishments for which we have access to recent, comparable data, as shown below.

Figure 2 – HMP Coldingley MOJ Comparator Prisons

Prison	Comparator Type	HNA For Comparison
HMP Buckley Hall	MOJ comparator prison	Yes (Tamlyn Cairns 2018)
HMP Lancaster Farms	MOJ comparator prison	Yes (Tamlyn Cairns 2018)
HMP Rochester	MOJ comparator prison	Yes (Tamlyn Cairns 2019)
HMP Onley	MOJ comparator prison	Yes (Tamlyn Cairns 2020)
HMP Featherstone	MOJ comparator prison	No (data from other sources, e.g. NDTMS, used where available and appropriate)
HMP Guys Marsh	MOJ comparator prison	No (data from other sources, e.g. NDTMS, used where available and appropriate)
HMP Haverigg	MOJ comparator prison	No (data from other sources, e.g. NDTMS, used where available and appropriate)

³ MOJ (2020) [Annual Prison Performance Ratings](#) (Supplementary Table 5 lists prisons by 'grouping').

HMP Erlestoke	MOJ comparator prison; recommended by prison	No (data from other sources, e.g. NDTMS, used where available and appropriate)
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The last three have only been used as comparators in relation to substance misuse.

We were unable to access a copy of the previous HSCNA for comparison purposes.

1.5 Report Overview

Part A of this report describes the 'story' of the establishment, specifically looking at:

- [Resident Demographics](#)
- [Healthcare Overview](#)
- [Physical Health \(LTCs\)](#)
- [Mental Health Needs](#)
- [Substance Misuse Needs](#)
- [Communicable Diseases](#)
- [National Screening and NHS Checks](#)
- [Self-Harm and Self-Inflicted Deaths](#)
- [Wellbeing and Health Promotion](#)
- [Social Care Needs](#)

There is a rationale and evidence base for the predictions we have used throughout Part A of the report; these are discussed and outlined in full in Part B, following the same themes as those in Part A. This includes reference to research, national policy, and service standards.

Chapter Two – Overview of HMP Coldingley

2.1 Prison Overview

HMP Coldingley is a category C training establishment for adult males, all housed in single cells. The operational capacity is 456.⁴ The prison closed a wing over 2019/20 and is expected to stay at the lower population for the near future at least. There are five main accommodation wings (A-E), a small, enhanced wing (F) and a new wing (G) comprising 60 accommodation pods. In addition, there are eight main workshops, an education block, and a range of administrative areas.



HMP Coldingley is one of the few prisons left in the country that still doesn't have in-cell integral sanitation (sink and toilet) throughout, i.e. two-thirds of residents have to ring the bell to be let out to use the toilet or wait until they are unlocked to 'slop out'. Notwithstanding issues of dignity, etc., this is clearly problematic from a hygiene and infection control point of view, particularly during covid-19. We are told that there are plans to ensure in-cell sanitation in the near future.

2.1.1 Other Reports

The most recent published full (unannounced) HMIP inspection of HMP Coldingley took place in March 2017, in partnership with the Care Quality Commission (CQC) and OFSTED.⁵ This was broadly positive about the regime but raised concerns about the impact of illicit drug use and was highly critical of the state of the fabric of the prison, particularly regarding the lack of in-cell sanitation. The most recent HMIP short scrutiny report⁶ was also highly critical of the lack of integral sanitation and the fact that there had been no hand sanitiser available for residents until HMIP brought this up. The last Independent Monitoring Board (IMB) report⁷ made the same criticism. The 2017 HMIP report is too dated to be of much practical use in informing this report, although we have referred to it where relevant. All of the recommendations from that report that are related to healthcare provision appear to have been addressed, with the exception of the level of dental provision (see [Oral Health](#)) and the point about integral sanitation made above.

More recently, HMP Coldingley was subject to a short scrutiny visit from HMIP. Findings and recommendations from this visit and similar visits to HMP Ranby and HMP Portland were published together in a report⁸ released in May 2020. The same visit was also incorporated into a larger aggregate report⁹ covering 35 prisons. We have referred to the shorter report where it is clear that the original reference was to HMP Coldingley.

⁴ MOJ (2020) [Prison population: March 2020](#). (accessed December 2020).

⁵ HMIP (2017) [Report on an unannounced inspection of HMP Coldingley by HM Chief Inspector of Prisons](#). (accessed December 2020).

⁶ HMIP (2020) [Report on short scrutiny visits to category C prisons 5 May 2020](#) (accessed December 2020).

⁷ IMB (2020) [Annual Report of the Independent Monitoring Board at HMP Coldingley 2019-2020](#) (accessed December 2020).

⁸ HMIP (2020) [Report on short scrutiny visits to category C prisons 5 May 2020](#) (accessed December 2020).

⁹ HMIP (2020) [Aggregate report on short scrutiny visits April - July 2020](#) (accessed December 2020).

The most recent IMB report¹⁰ was published in September 2020.

2.2 Implications of Prisoner Movement and Sentencing

2.2.1 Turnover Rate

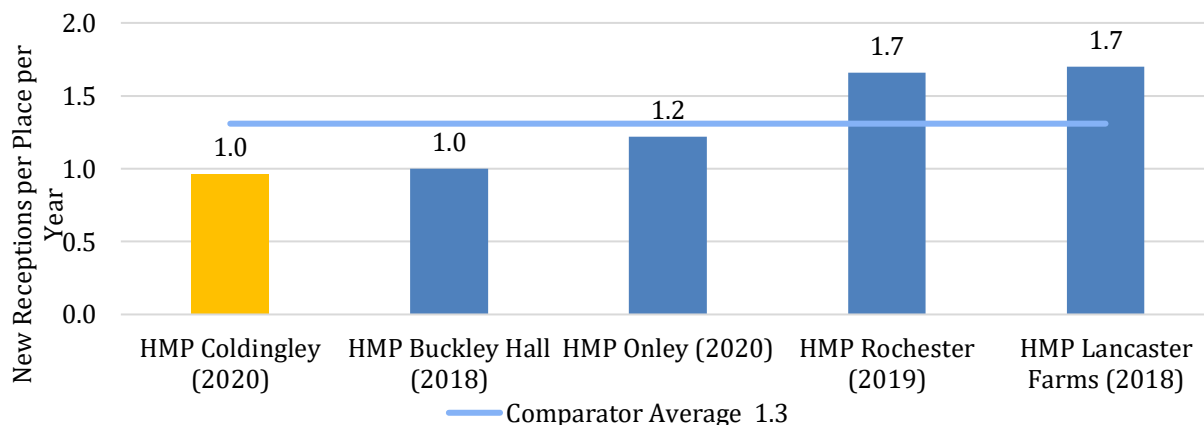
The following table shows annual numbers of receptions, transfers, and discharges from HMP Coldingley, as reported by the offender management unit (OMU).

Figure 3 – Receptions and Transfers/Releases

Total Numbers	2018/19	2019/20	2020/21
Receptions in from the community	0	0	0
Receptions in from other prisons	452	485	326
Transfers out to other prisons	424	331	202
Discharges/releases to the community	Reported as 'Not Known' by OMU		
Total number of residents in the prison during the period	Reported as 'Not Known' by OMU		
Average turnover/churn	Reported as 'Not Known' by OMU		
Recalls	0	0	0

The turnover rate, based on new patients recorded on SystmOne for 2019/2020, was 1.0 (1.0 new receptions per place per year). This is below the average turnover of comparator establishments shown below.

Figure 4 – New Receptions per Place per Year



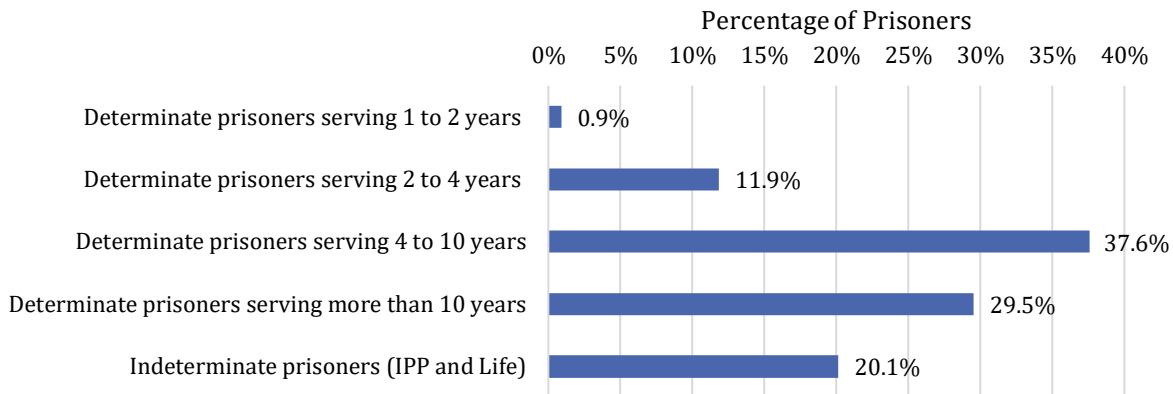
The implication of a relatively low turnover like this is that most residents are at HMP Coldingley long enough for any necessary assessments or screens to be carried out and, in most cases, for any necessary treatments to commence or be continued. Additionally, the relatively low demand to process new receptions and ensure continuity of care for those leaving the prison should ensure that these are done well.

¹⁰ IMB (2020) [Annual Report of the Independent Monitoring Board at HMP Coldingley 2019-2020](#) (accessed December 2020).

2.2.2 Sentences and Length of Stay

Eighty-seven per cent of the population of HMP Coldingley are serving sentences of more than four years.

Figure 5 – Population Status (OMU data)



The implication of this is similar to that of the low turnover, i.e. there should definitely be enough time during the person’s period of custody to ensure necessary assessments and screens and most treatment interventions. Additionally, many may be in custody long enough for their health to change, i.e. screening and access to healthcare interventions are important beyond the initial reception.

The chart below shows the length of stay for current residents at an October 2020 snapshot. Fifty-eight per cent of residents have been at HMP Coldingley for less than a year. This length of stay reinforces some of the points above, although with the proviso that some of the more spread out (e.g. annual) screens may miss some of the residents whose stays are shorter.

Figure 6 – Length of Stay (OMU data)

Length of Stay	Number of Residents	Percentage of Residents
Less than 1 month	11	2%
1 month to 3 months	83	19%
3 months to 6 months	77	17%
6 months to 1 year	87	19%
1 year to 2 years	121	27%
2 years to 4 years	51	11%
More than 4 years	17	4%

2.3 Resident Demographics

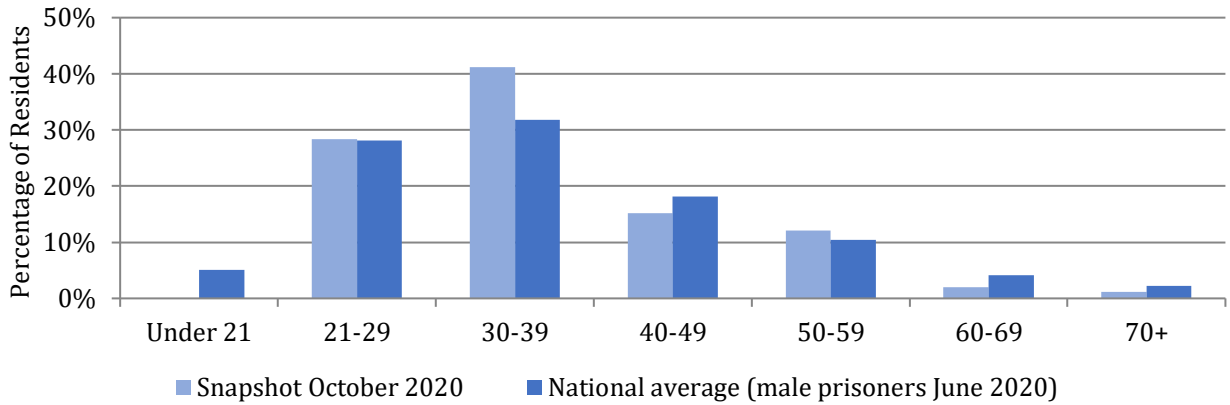
2.3.1 Age

The prison accommodates a mixed demographic of adults, as shown in the figure below. HMP Coldingley has a slightly younger age profile compared to the national average for male prisons, with 15% per cent of the population of HMP Coldingley being aged 50 or over; this compares to 17% nationally. HMP Coldingley has more residents in their 30s than the national average. This age profile fits its role as a working prison; a younger profile is less

likely to have the kind of longer-term health issues that are correlated with age and that would exclude them from work.

For the purposes of this report, the definition of older is 50+. When describing the prison population, this definition has been adopted by HMPPS and HMIP; it is consistent with those of AGE UK, the Prison Reform Trust and the charity RECOOP (Resettlement and Care for Older Ex-Offenders and Prisoners).

Figure 7 – Age Profile in Comparison to National Average

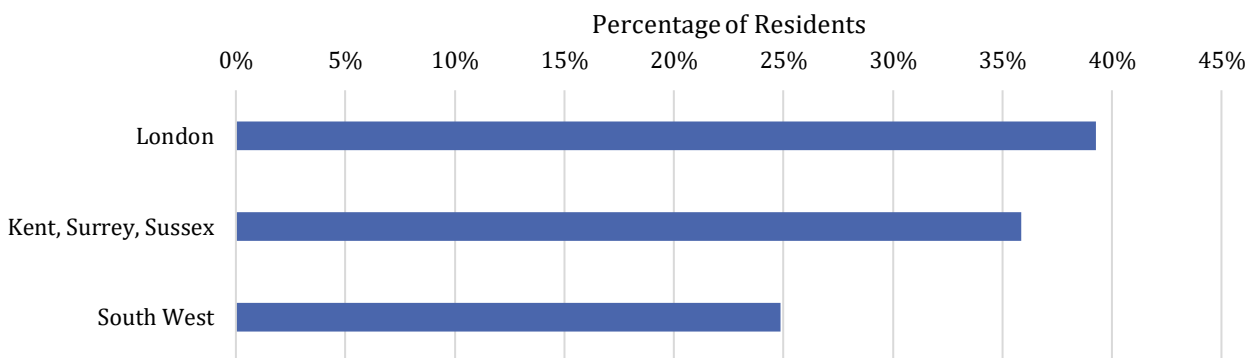


The youngest man at HMP Coldingley is aged 21 years old, and the oldest is 81.

2.3.2 Area of Home Residence

Data provided by the prison indicated which National Probation Service or contract package area the residents were from. As is apparent from the chart below, most are from the south of the country and within 100 miles of the prison. The main relevance in healthcare terms is that this may mean a relatively concentrated number of areas the prison releases to, and therefore a manageably finite number of local areas to deal with, potentially a small enough number to be able to establish and maintain pathways, etc. Central and North West London NHS Foundation Trust (CNWL) and Forward Trust are also providers of services in the community in the south-east and this may also help ensure continuity of provision and effective information sharing.

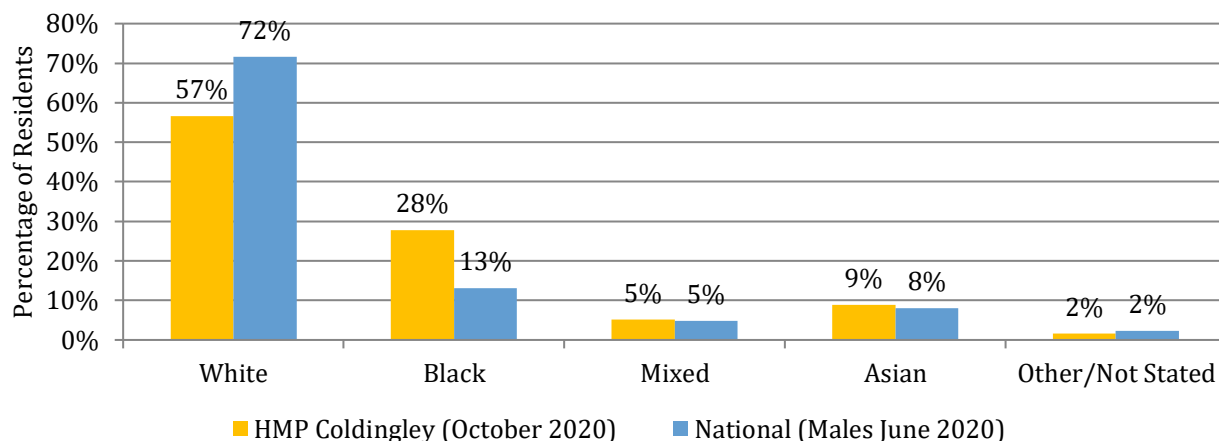
Figure 8 – Breakdown of Area of Residence (provided by OMU)



2.3.3 Ethnicity and Nationality

The profile of residents in HMP Coldingley is very ethnically diverse compared to that of prisoners nationally, with 57% of residents recorded as being from white ethnic backgrounds, compared to 72% nationally.¹¹

Figure 9 – Proportion of Residents in Each Ethnic Group



HMPPS states that across the prison estate nationally, 11.9% of the prisoner population consists of foreign nationals.¹² The same data shows that at October 2020, 9.6% (n=41) of the population at HMP Coldingley were foreign nationals. In the 2017 HMIP survey, 11.3% (n=16) stated that they were not a British citizen.

From a healthcare perspective, an ethnically diverse population may present a wider range of needs and impact on incidence and prevalence, as it is known that some physical health conditions are more prevalent in specific groups. For example, sickle cell disease is more common in people of African or Caribbean descent. Compared to the white British population, type 2 diabetes is up to six times more likely in people of South Asian descent, and up to three times more likely in African and Africa-Caribbean people.¹³ In a population the size of HMP Coldingley the impact of this will be filtered but will at times still be present.

2.3.4 Disability

We were unable to secure equalities data from the prison during the timescale of this report. SystmOne reported 33% of residents as having a disability of some kind. In the most recent HMIP report prisoner survey (2017),¹⁴ 16% self-reported any disability. This figure was lower than the HMIP comparator figure of 22%. The HMIP 2018/19 Annual Report showed 34% of male prisoners self-reporting a disability.¹⁵

Figure 10 – Residents with a Disability

HMP Coldingley	HMIP 2017 Self-report Survey	SystmOne Data (Snapshot October 2020)
Residents with disabilities	16% (n=22)	33% (n=147)

¹¹ Prison data provided by equalities team. National data from MOJ (2018) [HM Prison and Probation Service Offender Equalities Annual Report 2018/19](#) (accessed December 2020).

¹² [MOJ Offender Management Statistics Quarterly](#) (2020).

¹³ Diabetes UK webpage (2019) [Diabetes and Ethnicity](#) (accessed December 2020).

¹⁴ HMIP (2017) [Report on an unannounced inspection of HMP Coldingley by HM Chief Inspector of Prisons](#). (accessed December 2020).

¹⁵ HMIP (2019) [HM Chief Inspector of Prisons for England and Wales Annual Report 2018/19](#). Page 116. (accessed December 2020).

The equalities team at HMP Coldingley stated that 10 residents have a current personal emergency evacuation plan (PEEP).

Support is discussed in the [Social Care chapter](#) of the report.

SystemOne data indicated the following numbers of patients with recorded diagnoses of learning disabilities (LD) or autistic spectrum disorders (ASD); this is discussed in more detail in the [Mental Health chapter](#) of the report. There is no data on possible underlying reasons for any of these conditions.

Figure 11 – Learning Disability and Autistic Spectrum Disorder

HMP Coldingley	Population During 2019/20	Residents at Snapshot October 2020	Residents at Snapshot October 2020 (QOF register)
Learning disabilities	3.1% (n=27)	6.3% (n=28)	2.7% (n=12)
Autistic spectrum disorders	1.3% (n=11)	2.5% (n=11)	N/A

2.3.5 Sexuality

In 2017, HMIP reported that 1% of respondents in HMP Coldingley identified themselves as ‘homosexual’ or ‘bisexual’ (terminology is as used by HMIP). This was lower than the proportion reported in comparator HMIP data (4%) and the national data which also describes 96% of male prisoners as heterosexual.¹⁶

2.3.6 Transgender Residents

Part B of this report describes the health needs of transgender patients and the likely health inequalities and also includes further references to guidance documents. At the time of writing (December 2020), HMP Coldingley was holding less than five transgender residents. The average prison rate is two per 1000 (as described in Part B).¹⁷ The evidence base suggesting transgender individuals have a significant range of health needs and inequalities is robust and is summarised in Part B. Whilst the healthcare services likely to be needed by this cohort are largely the same as those used by the rest of the population, the likelihood of accessing these services can be greatly reduced.

CNWL is currently investigating the pathways for transgender residents in the men’s prisons, and the findings will help further inform the development of these pathways. Our discussions with prison and healthcare staff highlight some potential issues to consider.

Transgender residents may have health needs (e.g. for screens or treatments) from their birth gender as well as their current gender. These may be interventions their current prison does not routinely (possibly never) consider or carry out. It is important that each transgender resident’s healthcare needs are carefully considered with regard to both genders, e.g. with age-related screening for certain cancers.

Specialist services for transgender people are comparatively few and far between. If a transgender resident is actively involved in secondary care (e.g. if transitioning), then this care may be at a considerable distance from their prison. This may necessitate an unwanted

¹⁶ HMIP (2019) [HM Chief Inspector of Prisons for England and Wales Annual Report 2018/19](#). Page 116. (accessed December 2020).

¹⁷ MOJ (2019) [Her Majesty’s Prison and Probation Service Offender Equalities Annual Report 2018/19](#) (accessed December 2020).

transfer of secondary care, or logistical problems in accessing the existing secondary care. Telemedicine may offset some of this. This applies as much to specialist psychological support as it does to physical health.

Release planning can also be difficult due to the relative paucity of specialist services in the community.

Recommendation 1: Ensure transgender pathways are fit for purpose.

2.3.7 Homelessness

Homelessness is one of many factors that negatively impact on health. SystemOne data indicated that at October 2020, 4.7% (n=21) of the residents at HMP Coldingley were recorded as having disclosed being homeless during the year prior to imprisonment. This is a lot lower than the 12% average of comparator establishments. Eight per cent of the respondents to our survey described themselves as homeless. The offender management unit, the Community Rehabilitation Company (CRC) and Catch 22 all work together to try and ensure residents are not released homeless, but this can be challenging, particularly for those returning to London. There is generally enough time to do whatever can be done to ensure housing.

Homeless people, as noted in Part B, have a significant range of healthcare needs and health inequalities.

2.3.8 Armed Forces Veterans

The table below sets out data regarding residents' veteran status from SystemOne, and the most recent HMIP survey. The HMIP self-report of 4% is low next to the 6% self-reporting as veterans in the HMIP comparator data. The HMIP 2018/19 Annual Report showed 7% of male prisoners reported that they had been in the armed forces.¹⁸

As noted in Part B, veterans who are imprisoned are more likely to be convicted of sexual or violent offences. There was no data from the equalities team, though SystemOne snapshot data showed 11% of residents at HMP Coldingley recorded as veterans, much higher than the HMIP comparator. This is interesting in light of the prison's proximity to a military firing range (see [PTSD](#)). Healthcare implications for armed forces veterans are covered in Part B.

Figure 12 – Armed Forces Veterans

HMP Coldingley	HMIP Self-report Survey (2017)	SystemOne Data (Snapshot October 2020)
Armed forces veterans	4% (n=5)	11% (n=47)

2.3.9 Parents and Carers

This information is currently not recorded by offender management units (OMUs). The 2017 HMIP self-report survey contained one question regarding caring responsibility for children ('Do you have children under the age of 18?'). The proportion of residents in HMP Coldingley

¹⁸ HMIP (2019) [HM Chief Inspector of Prisons for England and Wales Annual Report 2018/19](#). Page 116. (accessed December 2020).

who reported being parents (52%) is slightly higher than the national rate of 50% for male prisoners reported in the HMIP 2018/19 Annual Report.¹⁹

The table below also shows parental status data from the national drug treatment monitoring system (NDTMS) for residents in substance misuse treatment during 2019/20; this is much higher than the HMIP self-report data, with 61% reported as being parents.

Figure 13 – Residents with Parental Responsibility

HMP Coldingley	HMIP Self-report Survey (2017)	NDTMS Data (2019/20)
Children under 18 years (all or some living with the prisoner)	52% (n=73)	10% (n=26)
Children under 18 years (none living with the prisoner)		51% (n=131)
No children under 18 years	48%	39%
Declined/missing data	-	0%

Note that all social visits ceased under covid-19, though the prison introduced various measures to help residents keep contact with their families such as extra money for calls and the use of mobiles and iPads.

2.4 Chapter Summary

- HMP Coldingley is a cat C working prison. The operational capacity is 456, all housed in single cells.
- Two-thirds of cells do not have integral sanitation.
- Turnover (based on SystemOne) is one, lowest in a range of comparators.
- Eighty-seven per cent of residents are serving more than four years, many will develop health issues during their time in custody.
- Sixty-one per cent are in HMP Coldingley for more than six months. This, and the low turnover, should allow sufficient time for screens and treatments.
- HMP Coldingley has more men in their 30s, and less aged over 60, than the national male profile.
- The prison has a very ethnically diverse population with 57% of residents recorded as being from white ethnic backgrounds, compared to 72% nationally.
- Numbers remain low, but there is a growing awareness of the needs of transgender residents and pathways are under review (see **Recommendation 1**).

¹⁹ *Ibid.*

Chapter Three – Healthcare Provision

3.1 Overview of Healthcare

As described in [Chapter One](#), NHS England and NHS Improvement has overall responsibility for the commissioning of prison healthcare in the region.

Central and North West London NHS Foundation Trust (CNWL) is the lead healthcare provider, as it is in the rest of the Surrey public sector prisons. This allows for several specialist roles that work across the Surrey prisons. Some aspects of healthcare are delivered by other (sub-contracted) organisations as listed below:

Figure 14 – Healthcare Providers

Element	Provider
Primary care	CNWL
GP	Medco
Dental	Tooth & Mouth
Optometry	Superspecs
Physiotherapy	First Community Health and Care
Podiatry	First Community Health and Care
Integrated SMS	Forward Trust
Mental health	CNWL (Secondary care only)

CNWL has a full-time performance lead for the Surrey prisons who monitors the Health and Justice Indicators of Performance (HJIPs) and other key performance indicators (KPIs), and goes through these every month with the heads of healthcare. This external support and monitoring should help ensure the various interventions involved, e.g. the monitoring of long-term conditions, flu vaccinations for vulnerable groups, and so on.

3.1.1 Healthcare and the Prison

Healthcare and prison governors felt that there were generally positive and effective working relationships and communication at all levels between healthcare staff and prison staff, and particularly so with regard to the challenges of covid-19. The independent monitoring board (IMB)²⁰ was positive about healthcare:

Healthcare provision is well regarded by prisoners and the Board hears very few complaints.

Prison governors were also positive, although one noted that healthcare’s ‘can do’ attitude did not always serve its interests as it could be seen as adequately resourced when it was not. Although communication was overall considered good, information sharing on specific residents could sometimes be slow or difficult, particularly if the person involved was unwilling to formally agree to information being shared by healthcare.

There are regular complex care meetings involving healthcare and the prison. These are attended by staff senior enough to be able to make decisions there and then as to how to best

²⁰ IMB (2020) [Annual Report of the Independent Monitoring Board at HMP Coldingley 2019-2020](#) (accessed December 2020).

manage and ensure the person’s care. This was one of several examples of good practice at HMP Coldingley.

3.2 Healthcare in HMP Coldingley

3.2.1 Healthcare Working Hours

Healthcare at HMP Coldingley is available seven days per week, and cover is provided between 7:30am and 6:30pm Monday to Friday, and between 7:30am and 5:30pm at weekends. There are no dedicated healthcare beds. Substance misuse hours and staffing are discussed in [Chapter Six](#), mental health in [Chapter Five](#).

3.2.2 Out-of-Hours Cover

Healthcare tries to anticipate potential out-of-hours (OOH) demands and discusses these with the residential staff in advance. During out-of-hours when healthcare staff are not on duty, the prison defaults to using OOH 111 services (who usually recommend A&E), or may contact an out-of-hours GP. Healthcare noted that a CNWL senior manager is also available on-call out-of-hours if needed, although it is not clear if many prison staff know that (or are meant to use this). Neither the prison nor healthcare reported problems with the current arrangement, although some felt that, ideally, there would be mental health (MH) cover at weekends too (see [Chapter Five](#)).

3.2.3 Primary Care Staffing

The following table describes the primary care staffing complement ([dental](#), [pharmacy](#), [mental health](#) and [substance misuse](#) staffing are discussed in the relevant chapters/sections).

Figure 15 – Staffing HMP Coldingley Primary Care

Role	Band (or Equivalent)	Full-time Equivalents	Comments
Head of healthcare	8b	1.0	
Primary care lead	7	1.0	
Lead nurse	6	4	
Staff nurse	5	2	1 vacancy
Associate practitioner	4	1.89	
Nursing assistant	3	1.0	
Senior administrator	4	0.8	Both admin do some work for mental health
Administrator	3	0.4	

Primary care felt that the staffing was probably adequate.

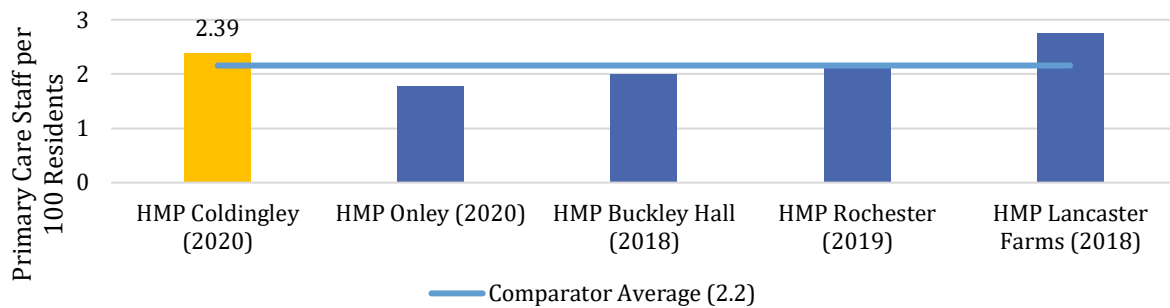
The head of healthcare is also a non-medical prescriber (NMP), although this is not part of her role and she rarely needs to prescribe. The mental health lead is also an NMP and the two NMPs can cover elements (though not all) of each other’s areas of work.

HMP Coldingley (in common with most prisons) has always found band 5 nurses hard to recruit and retain and has adopted the more common solution to this problem, i.e. use a combination of band 6s and 4s instead. This is more costly, but is a pragmatic solution and

does provide for more experienced staff and a degree of specialism that may be less present with band 5s. Other options being considered are to employ a paramedic, who would also be helpful in emergencies, e.g. new psychoactive substance (NPS) overdoses (note, NPS is on the HMP Coldingley risk register).

The chart below illustrates that the staffing ratio in HMP Coldingley is slightly above average next to comparator prisons where this information is available. Note that this is the *theoretical* staffing model and does not account for vacancies or staff on long-term sickness leave. At the time of the HSCNA, there was only one full-time vacancy. (NB: This chart includes only operational staff; it does not include admin provision as this is frequently described very differently between prisons).

Figure 16 – Primary Care Staffing HMP Coldingley and Similar Prisons



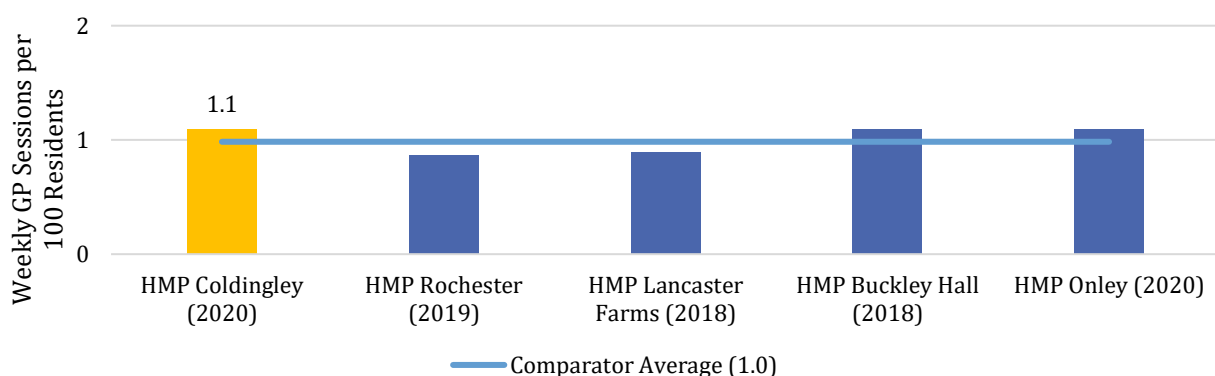
3.2.4 GP Provision

GP cover is provided by Medco, an out-of-hours service, subcontracted from CNWL. The GP contract is currently being re-procured for the final year of the existing broader healthcare contract for the Surrey prisons. At the time of writing (December 2020) it was still not clear who the contract had been awarded to.

GP availability is five sessions per week for primary care, with morning sessions from 8am-12 noon each weekday. A GP is available on call in the afternoons until 6pm. This is, in practice, only for phone advice, not to come into the prison. The same GP usually does three of the sessions, colleagues the other two. The service is well-regarded by primary care.

The level of GP cover in HMP Coldingley is about average among comparator prisons. Note that the GPs cover part of the primary mental health provision, specifically monitoring and reviewing any medical treatment, although they do not have the capacity to do this as effectively as a separate mental health specialist might.

Figure 17 – GP Cover Comparison



The lead GP felt that an extra session would allow for improved GP input to specialist clinics and more oversight of long-term conditions (LTCs), amongst other benefits.

3.2.1 Patients' Views

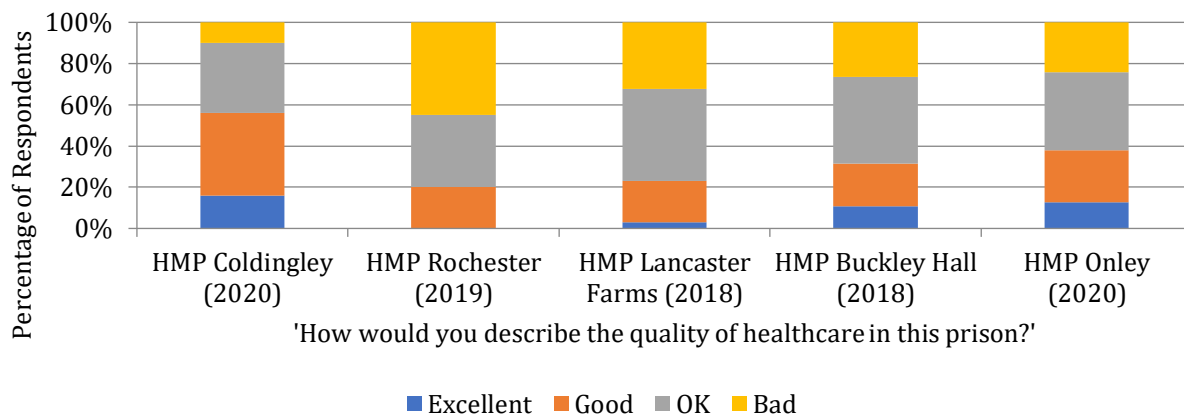
In the resident consultation, the percentage with positive views on healthcare was higher than any recently surveyed comparator prisons, with 54% of patients reporting that they thought healthcare was 'excellent' (15%) or 'good' (38%). From our survey:

"I think the healthcare doctors and nurses provide a very good service in this prison..."

From the recent EP: IC survey (see [section 3.2.2](#)):

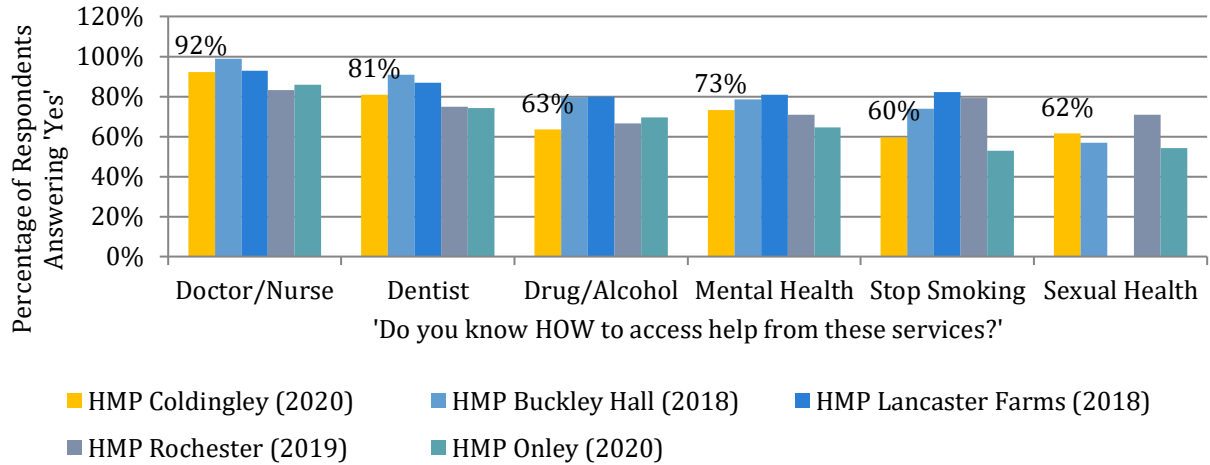
"I rate the healthcare and have been treated well up there. They are friendly and helpful."

Figure 18 – Opinion of Healthcare Overall (survey data)



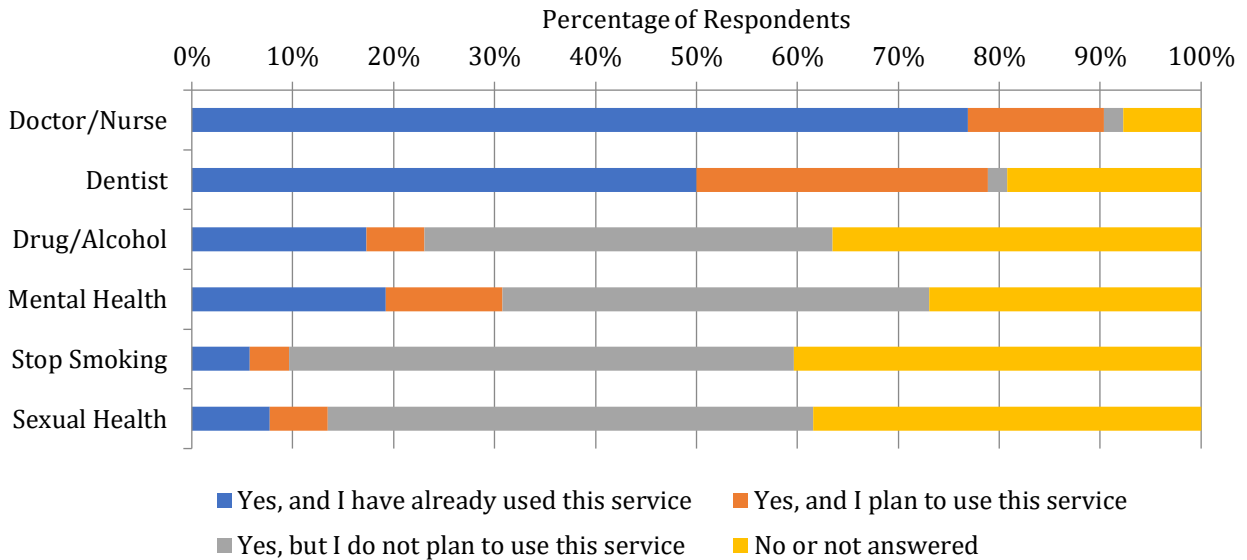
The proportion of respondents reporting confidence in accessing services was average compared to other similar prisons (note that sexual health services were not specifically asked about at HMP Lancaster Farms). Patients were most likely to say they were aware of how to access primary care services, and least likely to be aware of how to access smoking cessation services. EP: IC noted from its user surveys that there can be an issue of poor communication between healthcare and the resident body, and this may help explain why residents can be poorly informed on the healthcare provision. However, our experience is that if residents are asked what they would do if they experienced a particular health need, they often demonstrate that they would be able to find out.

Figure 19 – Confidence in Accessing Services (survey data)



For several services, there was a high proportion of patients who reported knowing how to access the service but did not plan to use it, as can be seen in the chart below.

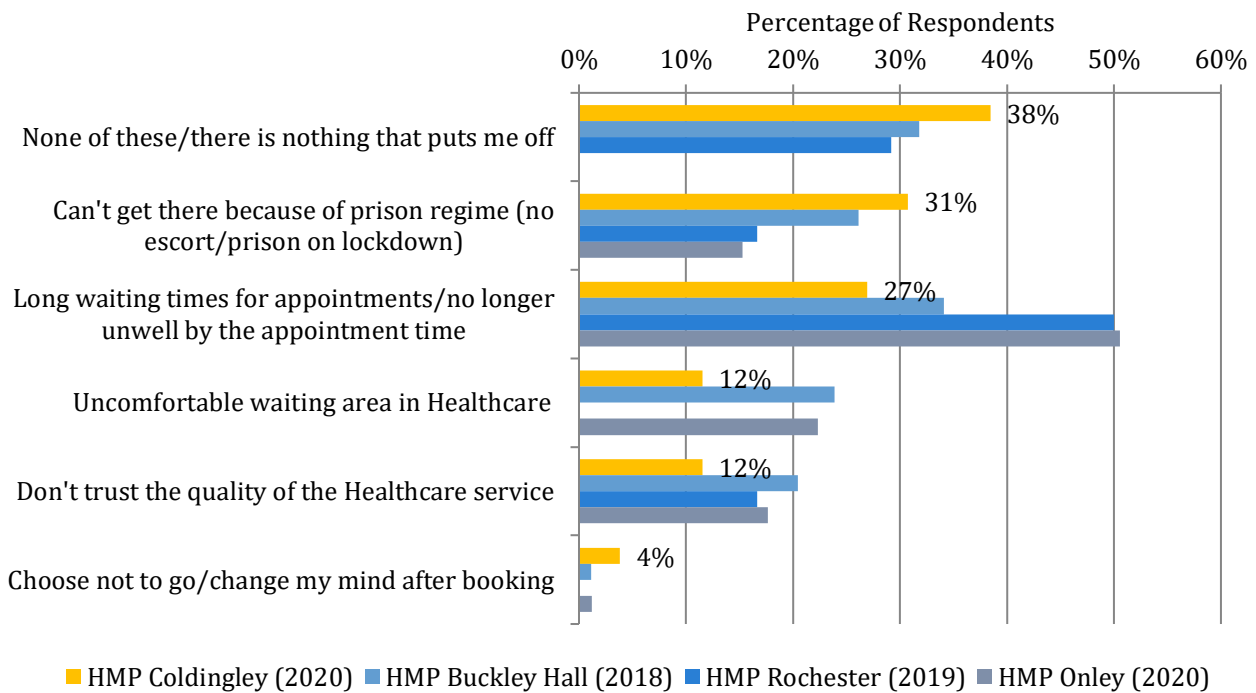
Figure 20 – Patient Access to Healthcare Services (survey data)



The above broadly reflects what we would expect in a cat C prison, i.e. that the kinds of needs that are more prevalent at the beginning of a sentence are less so by the time the person gets to HMP Coldingley.

Patients were asked ‘What stops you going to healthcare?’ The most common answer was that nothing put them off, followed by access problems because of the prison regime. It is likely that covid-19 had an impact on the answers to this question, particularly in terms of the comparators where we have asked this question pre-covid-19.

Figure 21 – Reasons for Avoiding Healthcare Visits (survey data)



3.2.2 Patient Engagement and Consultation

Patient engagement and consultation at HMP Coldingley is supported by EP: IC (a specialist NGO) which also covers HMP Send and HMP Downview. EP: IC is commissioned by NHS England and NHS Improvement to develop and support patient health forums (to run every six weeks) and to promote the user voice at strategic meetings. The contract began at the same time as covid-19 so it has been difficult to carry out the brief.

EP: IC has recruited and trained four forum resident reps. These are paid posts. They are supported weekly by group supervision with an EP: IC worker, although this support has ceased to be on-site lately because of covid-19 restrictions. The forums themselves are intended to be open to all residents, although have not run yet because of covid-19. EP: IC and the resident reps use a variety of methods to widely engage the rest of the residents in establishing what the priorities for consideration are, including surveys, focus groups, etc. They then establish a list of priorities, e.g. 85% were bothered they had to see a nurse before they could see a GP, 75% were bothered about waiting so long to see the dentist, and so on. The first survey (completed under covid-19) had 82 respondents, and the top four priorities were: 1) physiotherapy, 2) outside hospital appointments, 3) pharmacy/medications, and 4) mental health.

The reps then use further mixed methods (adapted for the population) to explore each particular topic one at a time and in detail, e.g. what could be better, what doesn't work so well, etc., as well as get the input of the relevant professionals on that issue. They try to make sure the wider prison population remain involved in all stages of the process and are informed as to the findings, any impacts, and the rationale for limitations. This is all written up in reports. Physiotherapy is to be the first issue to receive this focus.

Covid-19 has made the user engagement work much more difficult. EP: IC set up a freepost address and gave the relevant envelopes out with surveys, distributed by the health care staff. EP: IC has maintained contact with many of the respondents and encouraged friends and

families to share their views too, although there have not been so many of these responses. It is noticed that the longer covid-19 restrictions continue, the more people are becoming more difficult to engage, and that there may be some consultation fatigue. EP: IC also developed a covid-19 FAQ (frequently asked questions) that was sent to all the healthcare departments.

Additional to the above, primary care carries out its own monthly patient surveys. These are essentially satisfaction surveys and have a consistent set of questions, though different parts of the prison are targeted each month in order to avoid the questions becoming stale.

3.3 Healthcare Pathway

3.3.1 Arrival/Reception

Numbers moving from the remand prisons are reported to have declined since covid-19. Weekend receptions are very rare, and most are processed by lunchtime, i.e. there are always primary care staff on duty.

Primary care will usually know when a new reception is expected. The extent to which there is any advance information is highly variable, although sometimes the patient notes can be accessed through SystemOne. Complex patients will usually have been discussed in advance, especially if secondary mental health is involved. Both healthcare and prison staff felt that it was desirable for there to be more consistent transfer of health information with the prisoner, and that their medications should be ensured by the sending healthcare team and prison so that they arrived with sufficient medication to cover any gap until a prescriber was available.

Primary care is notified when the reception arrives and a nurse goes to reception to carry out the reception screen. Primary care has its own room in reception with a sink and a SystemOne PC. The reception screen may trigger a referral to substance misuse, mental health or one of the other specialist healthcare providers. Dry blood spot testing (DBST) and other tests are on an opt-in basis (opt-out might increase take-up). If necessary, screening tests are offered again on the secondary screen. All new receptions are also given written information about services.

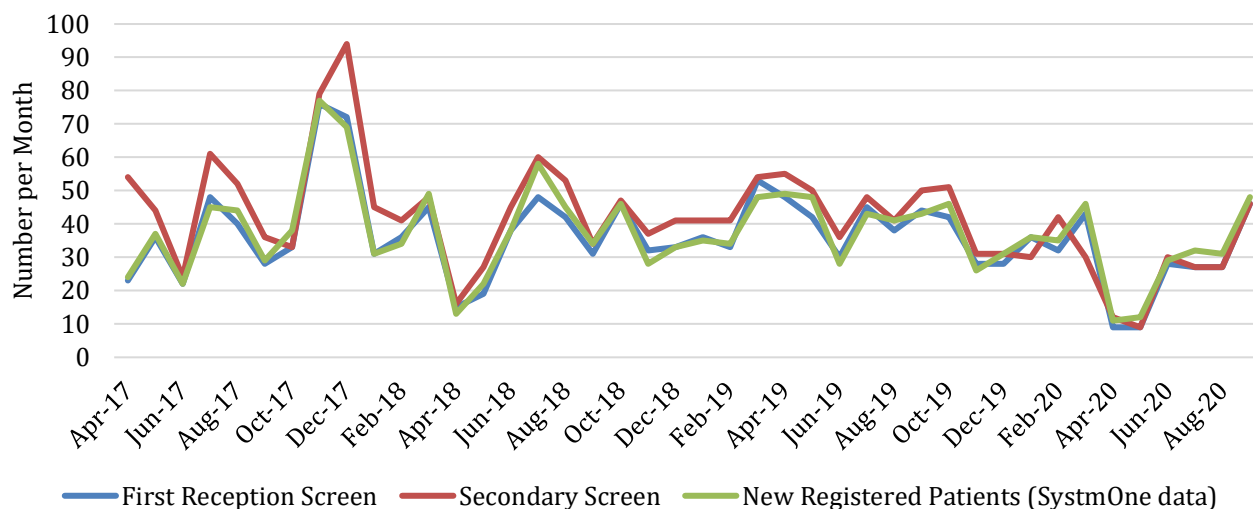
For the last six months, mental health has also been seeing new receptions at this point and doing the early days in custody screen. It was reported that men are tending to arrive at HMP Coldingley earlier in their sentence than they used to, and are more likely to still be adjusting to their sentence, i.e. may be anxious or depressed.

New receptions go straight to the reverse cohort unit, a separate landing that usually holds 10-12 residents. Men who go out for secondary care are only placed on this unit if an overnight stay was involved, otherwise they go out in mask, gloves and apron. Residents are reported to be generally happy with this arrangement. The secondary screens are carried out during the reverse cohort phase, in healthcare. There is a DVD outlining the healthcare provision at HMP Coldingley that is shown to inductions and at other times, e.g. in the healthcare waiting room.

SystemOne data shows that during 2019/20, 94% or more of newly registered patients were recorded as having received a first reception screening. While only 55% of new patients had a formally recorded (read coded) second screening on record, 92% had a record of various

checks that would typically be done as part of a second screen, suggesting one had been completed though not necessarily recorded.²¹

Figure 22 – Receptions and Reception Screenings (SystemOne data)



The reception pathway is appropriate.

3.3.2 Access to Healthcare

The process for accessing healthcare has changed since covid-19. The previous approach was centralised and largely application based. The apps had recently been reviewed to make them easier to read and with added pictures. App boxes were collected twice a day and screened by nurses in healthcare, with most booked in to the nurse practitioner clinic held each morning in primary care. Additionally, some residents would visit healthcare themselves to book an appointment.

The nurse clinic would triage, treat some, and refer others. Some would be booked straight into the parallel GP clinic if that appeared appropriate. GP follow-ups would already be booked in that clinic. Others might be signposted elsewhere, e.g. substance misuse service (SMS). If indicated during the nurse clinic, the nurse would consult with the GP and perhaps slot the patient in to see the GP there and then. Both the GP and nursing staff felt this generally worked well.

Since covid-19 this all still happens, but in addition, the nurses visit the wings each morning Monday to Saturday in what is essentially an open clinic. This covers a similar role to the screening of applications, as well as part of the role of the nurse practitioner clinic in healthcare. Needs are also identified during the medicines rounds. Primary care reports that roughly 70% of these concerns can be addressed there and then through advice, information, signposting, or referral elsewhere. This is both helpful where residents may not have previously raised these concerns, and useful in easing pressure on queries that would otherwise have been dealt with in the nurse clinic. If indicated, the person can also be booked in to one of the nurse or GP clinics in healthcare.

²¹ NICE (2019) [Prison second stage assessment](#) (accessed December 2020).

These wing clinics are coded the same as the nurse clinics in primary care and account for the large rise in numbers in that activity since covid-19. The current approach appears to be popular with both residents and wing staff and may be continued in some form post-covid-19.

On the 'red' wings, (i.e. the reverse cohort unit or where there has been a covid-19 outbreak), the nurses will do most of the above through the cell door: welfare checking each resident, triaging any concerns from the resident or uniform staff, and administering any medicines.

Under covid-19, residents are generally let out for clinics, etc. by landing to reduce infection risk, for both the wing-based drop-in clinics described above, or the traditional nurse practitioner and GP clinics. Pre-covid-19, residents would usually take themselves unescorted to healthcare for appointments, now most are escorted (not all).

Restrictions on numbers allowed in the healthcare waiting room (four residents, who must all be from the same landing) reduce the numbers that can access the centralised nurse and GP clinics, as well as those put on by visiting clinicians. There is also a limited escort resource.

As covid-19 becomes less of an issue, there will be an opportunity to consider the overall model of healthcare delivery, specifically the balance between wing-based and centralised provision. The former is more popular with prison staff and residents and makes for better identification of health issues and engagement with healthcare. However, it can be more demanding of healthcare resources, particularly within relatively small staff teams like at HMP Coldingley. The centralised approach is cheaper and reflects what happens in the community, though inevitably creates some distance between healthcare staff and residents and other staff. The outgoing healthcare link governor was very keen on a wing- and workshop-based approach, designed for minimum disruption to work. The incoming healthcare link governor feels services can be similar to the community, i.e. centralised and with time off work for medical appointments.

The previous model of provision was fit for purpose as is the current model under covid-19. There may be an option of a mixed approach post covid-19 e.g. medicines administration, and most clinics are centralised, but the triage process is more wing-based and open access. The various options should be weighed up and considered so as to get the best balance of effectively identifying and meeting need within the available resources.

Recommendation 2: Review the overall healthcare delivery model as part of the recovery from covid-19.

3.3.3 Impact of Covid-19 on Healthcare Provision

At the time of writing (December 2020), the prison had had two outbreaks of covid-19. HMP Coldingley is using a landing as a reverse cohort unit and one resident was shielding somewhere else. Note that as most are at the prison for some time, they become very settled in their cells and usually prefer not to move.

Staff reported that residents were largely understanding and accepting of the consequences of covid-19 at first, although this has declined over time and complaints have increased. Healthcare was hoping to bring in rapid-testing, but at the time of writing (December 2020) it looked like it might not be long before a vaccine became available so may be less necessary.

Healthcare staff continued to provide most primary care services and the standard of care remained higher than would be common in the community. However, the impact of covid-19 on access to specialist in-reach care (e.g. dentistry) was significant. The length of waits for these services was widely considered to be a problem by residents and staff, albeit that it was largely the same circumstance as in the community. Some of this provision has since recommenced, albeit in a limited way, and in most cases this will likely be back to normal within a few months after covid-19 restrictions are lifted. Secondary care was less affected (see [section 3.5](#)).

3.3.4 Release, Transfer and Continuity of Care

Most residents are transferred (usually to open conditions) rather than released. Transfers are generally straightforward. The prison is strong on resettlement and OMU works hard to make sure releases go as well as they can. Releases are booked into a discharge clinic run by the band 4 nurse. Naloxone (and training) is provided where appropriate. Enough medication is supplied (usually a week, can be more) to ensure this continues until new arrangements are made.

3.4 Clinics, Waiting Times and Did Not Attend (DNA) Rates

The wide range of primary healthcare clinics in HMP Coldingley is summarised below. The benchmark we use for waiting times for GP appointments is the Royal College of General Practitioners (RCGP) community average of no more than two weeks for a routine GP appointment.²² For all other appointments where any specific time limit is described, NHS England specifications²³ describe six weeks.

We have tried to RAG rate these clinics based on pre-covid-19 functioning as this is more relevant for informing future planning. Shortfalls during covid-19 are covered in the relevant discussions, usually linked to the comments on that clinic. The RAG rating is based on the frequency of the clinic, normal waits and normal DNAs, i.e. the extent to which things are in place to potentially meet need. The rating does not indicate the extent to which a particular need may be actually met, that is usually discussed separately and linked to the clinic comments. For example, a well-run and suitably staffed diabetes clinic is one step towards meeting the need, but will not do so if potential patients are not identified and referred.

Figure 23 – Clinic Frequency, Waiting Times and DNAs

Clinic	Reported Frequency or FTE	Waiting Time (current wait, working days)	DNA Rate (Apr-Sept 2020)	Observations	Needs Assessment (RAG)
Reception	As required, receptions can arrive any day Monday-Friday	N/A	0%	See Reception	
Secondary screening	As required	5 days maximum	0% (9% Oct-Mar)	See Reception	

²² Pulse (2019) [Average GP waiting times exceed two weeks for first time ever](#). (accessed December 2020).

²³ NHS England (2020) [Service specification Primary care service – medical and nursing for prisons in England](#) (accessed December 2020).

Clinic	Reported Frequency or FTE	Waiting Time (current wait, working days)	DNA Rate (Apr-Sept 2020)	Observations	Needs Assessment (RAG)
GP	5 sessions Mon-Fri mornings in the prison, and in the afternoon there is a GP on call	34 days - some non-urgent since covid-19 (not normally this long), 2 days maximum otherwise	3% (12% Oct-Mar)	Normally a consistent GP.	
Non-medical prescriber (NMP)	Two non-medical prescribers at present	2 days at most	N/A	Head of Healthcare and MH lead both NMPs, though neither employed as such.	
Nurse triage	5 times a week Mon-Fri	2 days maximum	11% (19% Oct-Mar)	See Access to Healthcare .	
Dentist	Every Friday – all day	Urgent - 6 days. Routine - 180 days since covid-19	3% (18% Oct-Mar)	See Oral Health	
Optician	1 session (1/2 day)	191 days since covid-19	Not reported (18% Oct-Mar)	See Optical Services	
Retinal screening	Visits the prison twice a year	101 days	Not reported (25% Oct-Mar)	Provided by Royal Surrey County Hospital (RSCH). See Retinal Screening	
Physiotherapy	1 session (1/2 day) a week.	Triage - 2 days. Routine treatment - 205 days since covid-19	Not reported (27% Oct-Mar)	See Physiotherapy	
Podiatry	Monthly	Long waiting list since covid-19	6% (7% Oct-Mar)	See Podiatry	
GUM	Monthly	155 days since covid-19	0% (13% Oct-Mar)	Dr Bennett - currently working remotely via phone. (See Sexual Health)	
Phlebotomy	3 times a week	4 days maximum	8% (20% Oct-Mar)	These can be run ad hoc as needed, or as part of nurse clinic if necessary.	
ECG	As required	1 week maximum	N/A		
Tissue viability	As part of nurse clinic	2 days maximum	N/A		
Vaccinations	As needed	2 days maximum	7% (26% Oct-Mar)	Usually done as part of the general nurse clinic, separate during flu season.	
Immunisations	As needed	2 days maximum	Unknown	Usually done as part of the general nurse clinic.	
Depot	Booked as required	2 days maximum	Unknown		
Sexual health	Once a week	1 week maximum usually	Unknown	Not covered if nurse absent. (See Sexual health).	

Clinic	Reported Frequency or FTE	Waiting Time (current wait, working days)	DNA Rate (Apr-Sept 2020)	Observations	Needs Assessment (RAG)
Asthma	As required	2 days maximum	Unknown	See Asthma	
Diabetes	As required	2 days maximum	0% (17% Oct-Mar)	See Diabetes	
CHD	Patients booked to be seen as required in nurse clinic	2 days maximum	Unknown	See Hypertension and CHD	
Hypertension	Patients booked to be seen as required in nurse clinic	2 days maximum	Unknown	See Hypertension and CHD	
Epilepsy	Patients booked to be seen as required in nurse clinic	2 days maximum	Unknown	See Epilepsy	
NHS Health Checks	Waiting list monitored by performance lead and nurse book into clinic as required	2 days maximum	Unknown	See Health Checks	
Older persons clinic	Ad hoc or in nurse clinic as required	2 days maximum	Unknown	Usually over 55, younger if complex or high need. Named nurse.	
Discharge clinic	Patients booked to be seen prior to release	N/A	Unknown	See Release	
In-possession spot checks	1 x week	N/A	Unknown	See Pharmacy and Medicines Management	
Mental health annual physical health checks	As required	Unknown	Unknown	See Health Checks	
Fibrosan	As required approx every 3-4 months	Up to 1 month	Unknown	Machine shared with HMP Send. Three nurses trained, close links with hepatology.	
Weight	In nurse clinic as required.	2 days maximum	Unknown	See Weight Management	
Pain	Every 2 weeks, 1 session, ½ day	2 weeks maximum	Unknown, but reported as common	Led by pharmacist and GP. See Pharmacy and Medicines Management	
Pre-op assessment	As required	2 weeks maximum	N/A	Depending on the department, assessments can be completed at the prison, or patient may need to go out to hospital.	
Bowel screening	As required	1 week maximum	N/A	A clinic can be set up if enough numbers, otherwise patients seen individually and given the single test. See Bowel Cancer Screening	
AAA screening	Annually	1 year	N/A	Provided by RSCH.	

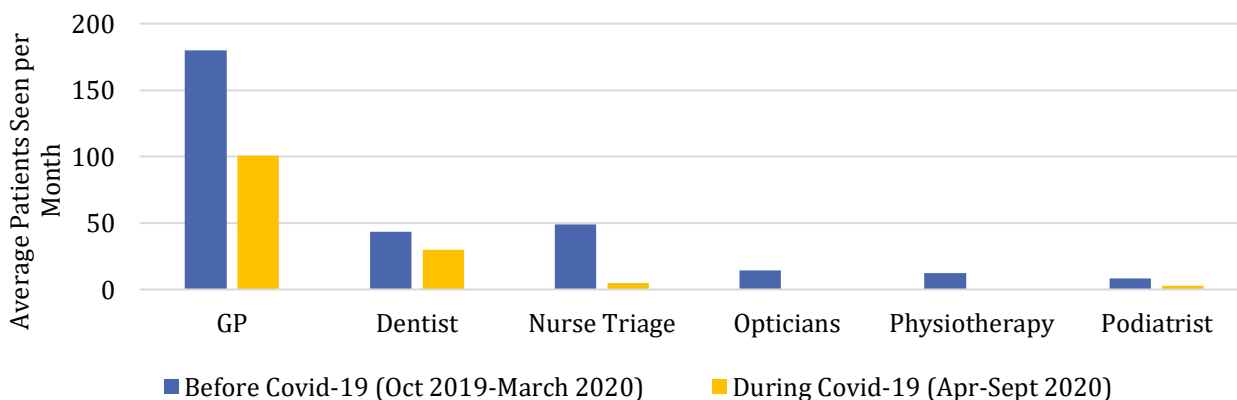
The capacity of healthcare services to meet needs is partly dependent on the number of patients booked into each clinic, and then also on the proportion of booked patients who actually present to a clinic. Patient non-attendance can impact waiting times for a service and thus its ability to meet needs.

NHS England states that ‘did not attend’ (DNA) rates should not exceed 10%. Across the range of health needs assessments (HNAs) conducted by our team, we found that the average DNA rate across primary care clinics has dropped from 20% to 13%. Across four comparators of HMP Coldingley²⁴ (between 2018-2020), the average DNA rate for primary care clinics was 19%. HMP Coldingley reported an average DNA rate across primary care clinics of 3% between April and September 2020. However, this may have been affected by restrictions due to the covid-19 pandemic, since the DNA rate during a more ‘normal’ period (October 2019 to March 2020) was 13%. This was equivalent to the average of all prisons, lower than comparators, and exceeding the rate determined in the NHS England specification. Healthcare reports that this is due to the rise in the use of escorts since covid-19, as previously some residents would make appointments in order to be able to go for an unsupervised walk (and then not turn up).

The average proportion of booked appointments actually fulfilled at HMP Coldingley was reported to be 95% between April and September 2020 (86% between October 2019 and March 2020). Clinic occupancy varies considerably between clinics and, for some, is contributed to by ‘no access’ appointments (patients unable to attend due to factors outside their control, such as prison regime – however, this only applied to 2% of appointments on average).

For some clinics, the clinic occupancy rates, DNA rates and numbers of appointments in the last six months (April to September 2020) were quite different from that in a six-month period before the covid-19 pandemic (October 2019 to March 2020), though for some there was little change. The chart below shows the average number of patients *seen* per month (so excluding those who did not attend) in a selection of clinics recorded on SystemOne, both before and during the pandemic. This illustrates some of the impact of the pandemic on the day-to-day operations of healthcare –many clinics have seen a drop in monthly appointments.

Figure 24 – Patients Seen per Month in Clinics Before and During Covid-19 (SystemOne appt. data)

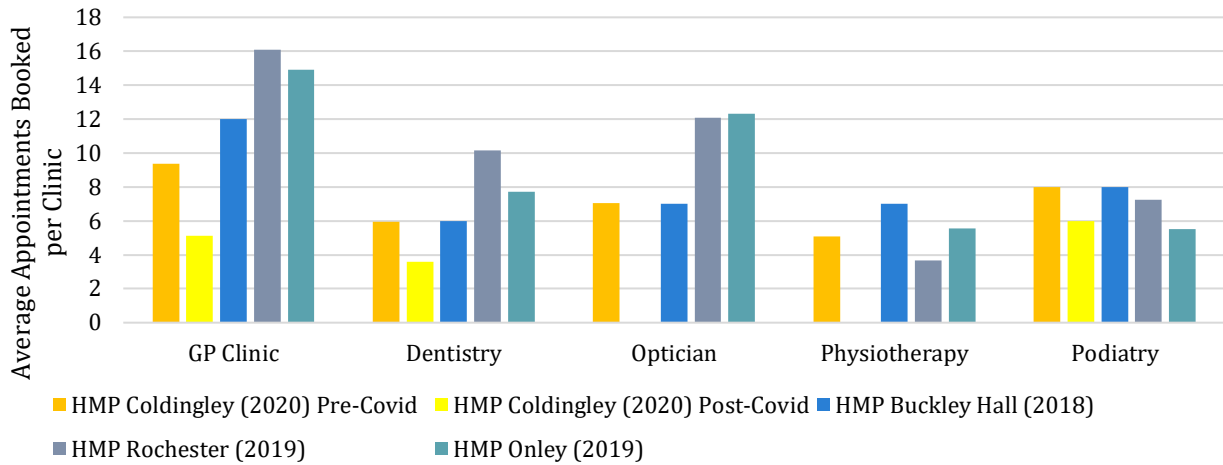


Reporting on the number of clinics presents a partial picture. A supplementary issue is how many patients are booked or seen per clinic. The chart below illustrates the average number of appointments booked (planned) per clinic at HMP Coldingley before and during the pandemic and compares this to (pre-pandemic) activity at comparator prisons.

The numbers of planned appointments for primary care clinics at HMP Coldingley appear to be generally a little lower than comparators, even under normal circumstances. Of note is the lack of optician and physiotherapy clinics during covid-19.

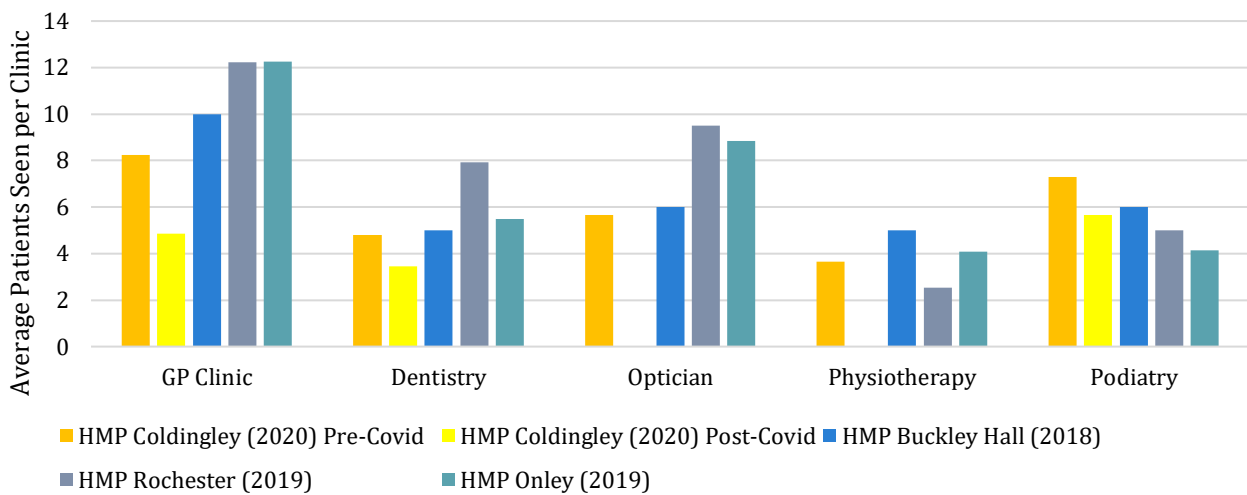
²⁴ HMP Buckley Hall (2018); HMP Lancaster Farms (2018); HMP Rochester (2019); HMP Onley (2020).

Figure 25 – Number of Appointments Booked per Clinic Comparison



We were also able to look at numbers of appointments fulfilled per clinic at HMP Coldingley and the other prisons. This is shown in the chart below. These follow a similar pattern to the previous chart, with the greatest drop-off from booked to seen (under normal circumstances) in dentistry and optician services, although these DNAs are still relatively low.

Figure 26 – Numbers Seen per Clinic Comparison



Our conclusion is that HMP Coldingley has a largely appropriate system of clinics, mostly acceptable rates of DNAs, and normally a mostly acceptable length of waits, although patients clearly prefer as short a wait as possible for most things. This is equitable with community provision, if not better in several areas. There are however several gaps in this picture currently as a result of covid-19, all discussed in the relevant places in the report. Overall however, we do not feel it should be too difficult to return to the previous level of functioning once covid-19 is no longer an issue. If extra resources are deployed as recommended, most things could be back to normal within a few months.

3.5 Secondary Care

HMP Coldingley has recently had telemedicine set up, and as this develops, it should increase access to secondary care whilst decreasing the use of escorts for outside appointments and the length of waits in general.

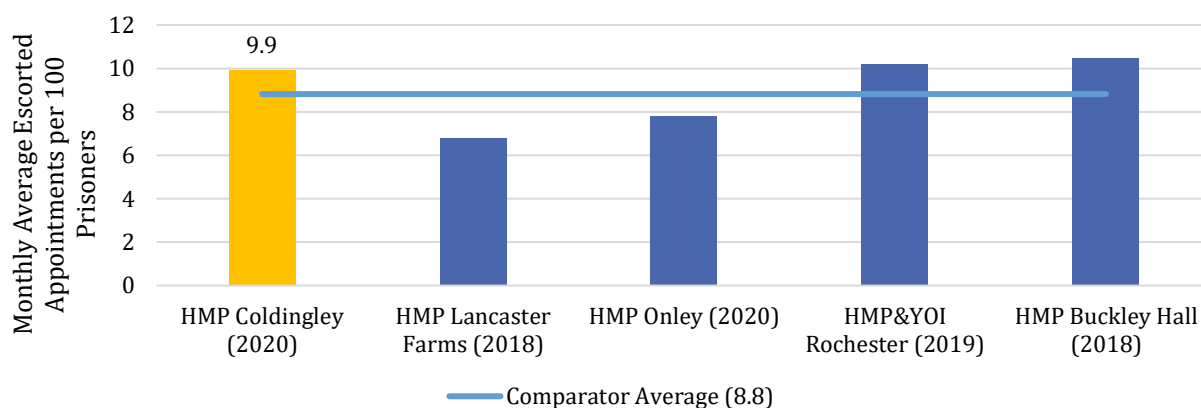
Staff felt this, and the increased use of telephone consultation generally, had been invaluable during covid-19 and had meant that it was largely possible to maintain secondary care treatment. It is particularly supportive of follow-up. Nurses always sit in on the calls. Residents prefer this approach to the outside visits which many of them find humiliating (they are usually handcuffed and always escorted). Several of the secondary care clinicians who used to insist on face-to-face appointments are currently working from a distance and it is expected that at least some of this will continue post-covid-19.

3.5.1 Prisoner Escorts and Bedwatches

Two escorts per weekday are profiled. This is the same two officers for the whole day, meaning that if they are not able to be back in time from a morning escort, then the afternoon escort will not take place. Primary care was clear that more escorts were needed.

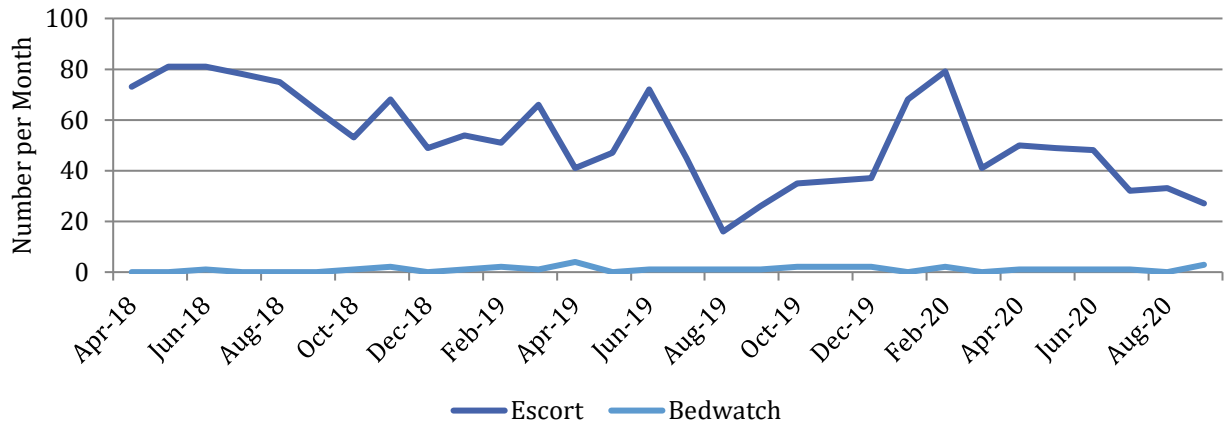
There was an average of 45 escorts and 1.3 bedwatches per month during 2019/20 (taking a time prior to the covid-19 pandemic as an indication of more 'normal' activity). This is a slightly above average rate of escorts per 100 residents compared to other similar prisons for which this data was available. This is not to say that the allocation is sufficient, just that it is similar to other establishments. Note that telemedicine should reduce some of the need for external escorts.

Figure 27 – Escorts per Month per 100 Residents Comparison



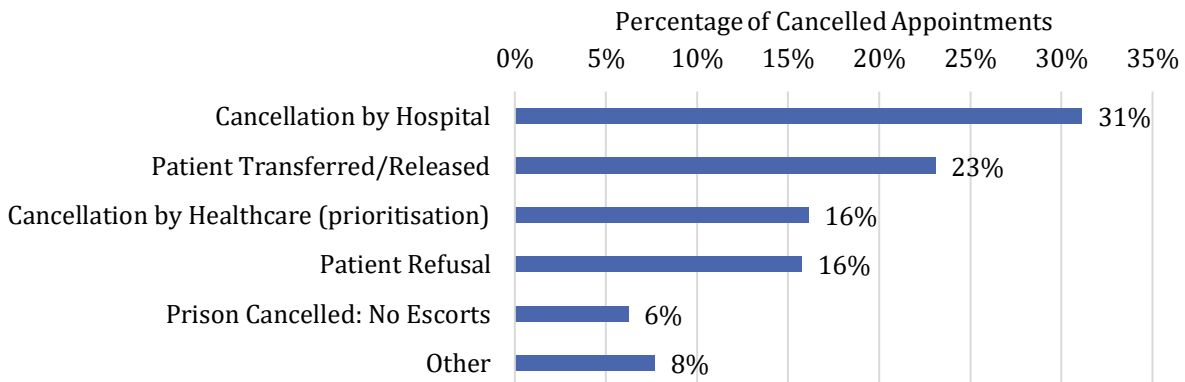
Healthcare was able to provide details of hospital appointment over the past few years. As the chart below shows, there have been considerable fluctuations in the numbers of monthly escorts in recent years. An understandable reduction in appointments is apparent since covid-19, although this is not as pronounced in comparison to 'normal' activity as we have seen in other prisons.

Figure 28 – Escorts and Bedwatches per Month (healthcare data)



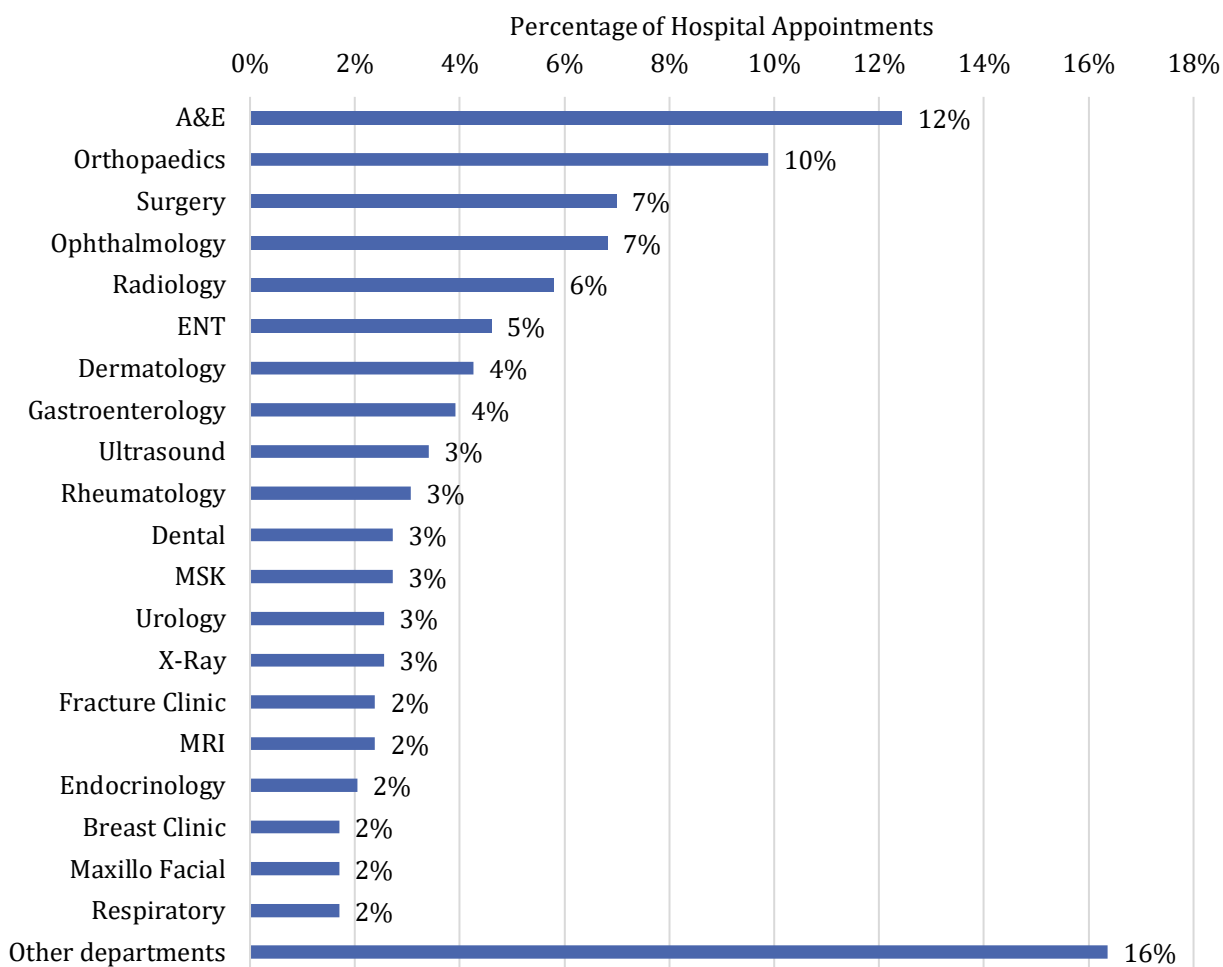
Primary care reports that the escort arrangements described above led to lots of cancellations, with resultant impacts on resident care and morale. The data showed that of 273 cancelled hospital appointments during 2019/20, a third were cancelled by the hospital the patient was due to attend, while 23% were cancelled due to the patient no longer being in the prison. A further 16% were cancelled due to prioritisation of a more urgent appointment, while 16% were cancelled due to patient refusal. This suggests that while the escort arrangements do impact on missed appointments, this is not to the same extent as several other factors.

Figure 29 – Escort Cancellation Reasons (healthcare data)



During 2019/20, data provided by healthcare indicated that the most visited hospital departments were A&E, orthopaedics, ophthalmology and surgery.

Figure 30 – Hospital Departments Visited 2019/20 (healthcare data)

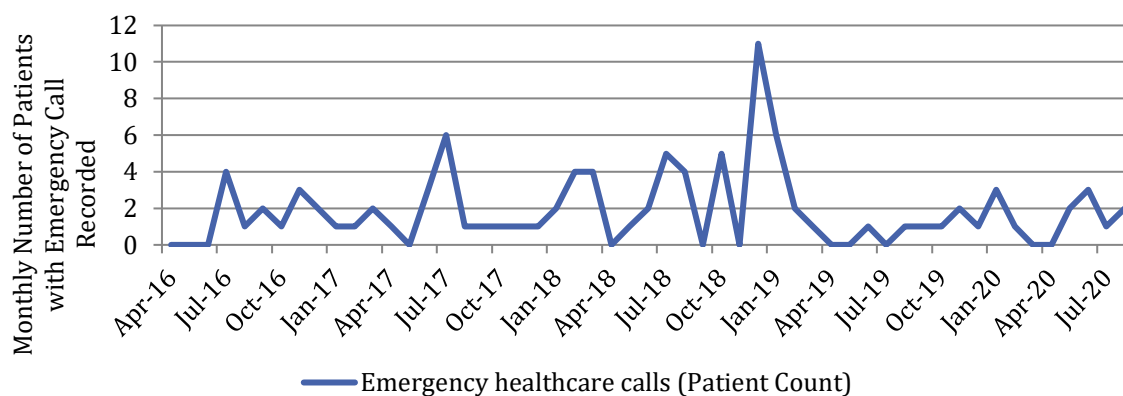


Prior to the introduction of telemedicine, we would have agreed with primary care that a greater escort provision would be ideal. However, we feel that telemedicine at HMP Coldingley has yet to reach its potential and may reduce the demand for escorts to a sufficient level to match allocation. With respect to the possible impact of telemedicine, there may also be some advantage in the future of reviewing the cost-effectiveness of other visiting diagnostics, e.g. x-rays and ultrasound, particularly as the latter already covers three others of the Surrey prisons. We suggest revisiting this issue in at least six months’ time to see if the escort resource remains inadequate.

3.5.2 Emergency Calls/Codes

A ‘code’/emergency call to healthcare automatically triggers a call for an ambulance which healthcare may stand down. SystmOne data showed low numbers of instances of the read code ‘healthcare emergency response’ being recorded over the past few years, with an average of one per month recorded during 2019/20. Emergency responses may sometimes be recorded on SystmOne as either a ‘code blue’ or a ‘code red’; there were no code blues recorded in the past few years, but an average of one ‘code red’ per month during 2019/20.

Figure 31 – Emergency Healthcare Response Records (SystmOne data)



The IMB report²⁵ describes an average of roughly two code blues and roughly one code red per month up to July 2020, different figures from those recorded on SystmOne and likely more representative of medical emergencies in the prison. The recording on SystmOne could usefully be made more consistent.

Recommendation 3: Ensure consistent recording of emergency codes on SystmOne.

Healthcare anecdotally reported a low level of emergency codes and that these were generally appropriate, particularly since reviewing the criteria with the prison. Primary care encourages the uniform staff to phone for advice if they are uncertain and they would then examine the resident themselves if this was indicated. This approach helps reduce the unnecessary use of codes.

Our conclusion is that medical emergencies and the use of emergency codes are comparatively infrequent and are generally used appropriately, i.e. there are appropriate pathways and protocols for emergencies.

3.6 Oral Health

Part B explores dental care need.

3.6.1 Dental Facilities and Provision

There is a fully equipped dental suite in healthcare and the dentist stated that the equipment is generally fit for purpose and modern, i.e. good chairs, digitalised services, radiograph, etc. The dentist noted that residents often have much worse oral hygiene than most people in the community.

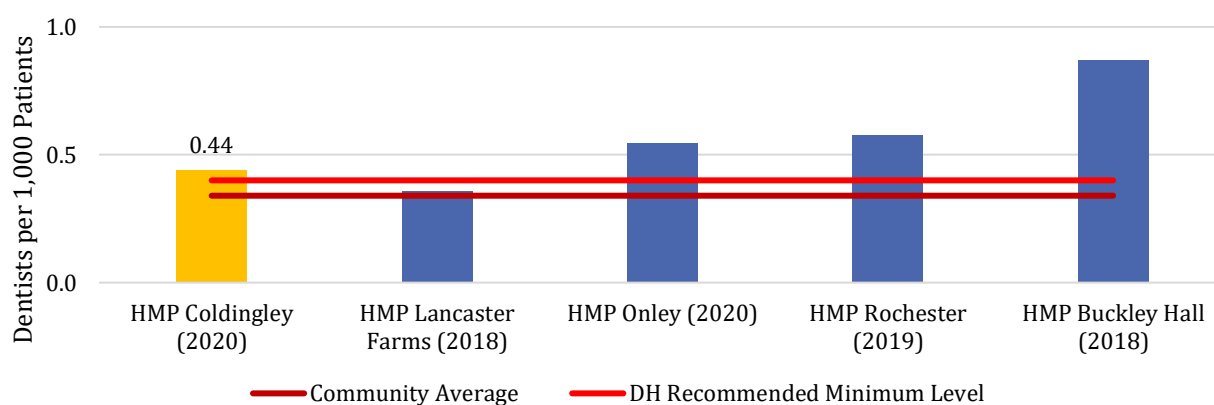
Dental provision is from Tooth and Mouth, which covers all four of the public sector Surrey prisons. Tooth and Mouth tries to have consistent staff involved at each prison. Each session is a dentist and a dental nurse, although the lead dentist reports using a dental therapist and oral surgeon on occasion as needed (these will be a separate extra session or when the dentist is absent). Tooth and Mouth is trying to develop a new model where these other staff are more embedded in the core provision. The lead dentist would like, in the long run, to do less ‘drill and fill’ and more on prevention and good oral care, etc.

²⁵ IMB (2020) [Annual Report of the Independent Monitoring Board at HMP Coldingley 2019-2020](#) (accessed December 2020).

The normal dental pathway is: application ⇒ dental triage ⇒ dentist check-up ⇒ treatment plan ⇒ dentist, sometimes therapist or surgeon ⇒ secondary care if indicated. The dentist felt there may be potential in training one or more of the primary care staff in dental triage so patients could be booked straight in for treatment if necessary. Urgent appointments were always prioritised into the next clinic pre-covid-19.

Provision is commissioned at two dental sessions a week. There are two ‘floating’ sessions for Surrey as a whole and one of these has long been allocated to HMP Coldingley in recognition that two sessions were not enough there. In other words, in practice, there are three sessions per week at the prison. The chart below shows the commissioned level of dental cover in HMP Coldingley compared to other similar prisons (dentists per 1,000 patients; this does not include therapist or hygienist provision to ensure comparisons between establishments are looking at the same provision). At the commissioned two sessions per week, dental cover at HMP Coldingley is below average relative to comparator prisons, although theoretically adequate compared to the recommended minimum cover.

Figure 32 – Dentist Cover Comparison (dentists per 1,000 patients)



The three sessions delivered weekly in practice were considered by healthcare and the dentist to normally be an adequate level of cover pre covid-19, and we suggest that this becomes the commissioned normal level of provision.

Recommendation 4: Increase the commissioned dental provision to at least three sessions per week, with optional extra sessions to limit waiting lists appropriately.

However, since covid-19 the waiting lists have grown considerably. This is partially due to infection control measures reducing the numbers that can be seen, and partially due to the stopping of most aerosol generating procedures (AGP – e.g. drilling) for much of the pandemic due to the transmission risks involved. At the time of interview (December 2020), only urgent cases were seen and only the level 3 were treated with AGP if required. In many cases the patient has to manage with antibiotics and painkillers. As a result, waiting lists for both check-ups and treatments are 40 weeks, although air filtration units were purchased to reduce fallow time and to allow increased activity. Amongst the comments from our patient surveys, we received a number complaining about the waits for the dentist and there were similar comments in the EP: IC survey. Additionally, there are risks from the overuse of antibiotics and the overall health strategy is to reduce the use of painkillers rather than increase them.

In the past, extra dental sessions have periodically been commissioned by NHS England to get the waiting lists back below the six-week standard and it expected that this will happen again once covid-19 relaxes. Extra sessions in the meantime would make little difference to the

treatment waits if AGP was needed. There are potential ways around this problem involving air filters and different equipment, etc., but these would involve extra capital costs, extra equipment, less patients per clinic and, in practice, are not feasible in time to help with the waits.

Dentistry was initially sub-contracted from CNWL but was then changed to being directly commissioned. This has led to a reliance on legacy arrangements via CNWL such as equipment maintenance, IT licences and stock ordering, all of which the dentists felt would be better if they were directly responsible for. The dentists have their own software and record systems and need this for their own reporting. They duplicate records to SystemOne, which apparently cannot deliver the reports the dentists need.

Our conclusion is that a standard provision of three sessions per week should normally be adequate to meet the need. Extra sessions will be needed to clear the covid-19 backlog of check-ups and treatments and extra sessions should be used in the future, if necessary, to ensure waits stay under six weeks.

3.7 Optical Services

Optometry is delivered by Superspecs, sub-contracted from CNWL. It is usually the same optician involved, who also covers the other public sector Surrey prisons. Provision is normally four sessions a month at HMP Coldingley and this was considered adequate under normal circumstances. Clinics continued for a while during covid-19 but stopped more recently and the waiting list is building up. Staff are concerned about the gap in provision, although the prison bought dozens of cheap reading glasses to at least temporarily address that issue. The optician is flexible and able to provide extra clinics as needed, so should be able to address any backlog quickly once clinics recommence, and that is the plan at HMP Coldingley.

The optician reported that referrals were sometimes vague or even incorrect, particularly those from officers, but the nature of optometry was that triage was difficult as it required a degree of expertise in the first place. All new receptions were asked if they wanted to see an optician, the optician suggested this could be changed to asking if they might need to see an optician, in order to reduce the unnecessary referrals and subsequent DNAs by people who didn't feel the need to see him.

In terms of need, the optician reported that the health of residents' eyes was broadly similar to that of their peers in the community. Secondary care was rarely needed, though straightforward to access if necessary. The most common interventions were eye examinations and the provision of glasses. He does not have the equipment for contact lenses. The optician carries a selection of cheap reading glasses if needed, particularly as residents are not allowed to have prescription or reading glasses sent in (unless a healthcare professional in the prison has established what the prescription need is). The optician noted that he would ensure any prescription glasses that had been arranged reached the resident, if necessary, sent on to their next establishment or to an address in the community if they had been released.

The optician had his own template on SystemOne and entered the information directly. This could usefully be copied by opticians elsewhere. He reported that existing records were often poor or non-existent.

Our conclusion is that the need for optical services is normally adequately met, though waiting lists have developed unacceptably as a result of covid-19 and extra sessions will be needed to clear the backlog.

3.8 Physiotherapy

There are three full-time physiotherapists covering HMP Send, HMP Downview, HMP High Down and HMP Coldingley. They can cross cover but tend to arrange their clinics so it is not usually necessary. Clinics are set days, though they have been a lot more flexible under covid-19. The resource is meant to be one clinic per week at HMP Coldingley. The physiotherapist thought there needed to be two clinics per week to avoid large waiting lists. Healthcare and the prison also thought more sessions were needed.

Covid-19 has had a considerable impact. It has been agreed that physiotherapy will only be for urgent appointments and the lead physiotherapist oversees all referrals and prioritises these through SystmOne. However, even urgent appointments have proven difficult under covid-19 restrictions, often because of escort issues.

HMP Coldingley was still running clinics throughout the pandemic, but stopped in the second lockdown. There were expected to be 17 on the waiting list by the end of November, although the physiotherapist was confident this would be largely cleared by the end of December, assuming the new lockdown was limited.

Delivering extra clinic sessions would potentially help to clear the backlog, however, many assessments generate further follow-ups that are in turn difficult to address, meaning some patients just move from an assessment waiting list to a treatment waiting list. Additionally, the existing physiotherapists do not generally have the capacity to deliver extra sessions. Nevertheless, this option should be taken where possible.

Overall, we recommend that the standard resource is increased to two sessions per week at HMP Coldingley, with extra sessions if necessary until any backlog is cleared.

Recommendation 5 – Increase the physiotherapy sessions to two per week, along with temporary extra sessions to help clear any backlog.

The physiotherapist reports that in contrast to the women's prisons, there is generally more demand at the male prisons, the difference partly as these are bigger establishments, partly due to a greater level of injuries from exercise and sports, particularly at HMP Coldingley where the gym is well-regarded and very popular.

Referrals are generally via the GPs or nurse practitioners in order to ensure their appropriateness and to ensure serious non-physiotherapy concerns have been picked up. The physiotherapists manage their own lists through SystmOne.

Each clinic has some new assessments but is otherwise mostly follow-up treatments. Normally, physiotherapy can see the more urgent cases within two weeks, e.g. post-surgery or worsening neurological symptoms.

There is an ongoing demand for appointments relating to chronic pain. The lead pharmacist felt that the physiotherapy input was valuable in reviewing pain management and reducing the use of pain-control drugs. On the other hand, these appointments apparently account for a

lot of DNAs, perhaps as the patients are trying to avoid reduction or removal of their pain-control medicines (see [Pain Control](#)). The physiotherapist also described a historical problem with sometimes dubious presentations aimed at getting orthopaedic chairs and mattresses, although these appear to have largely ceased.

3.9 Podiatry

The service is delivered by First Community Health and Care (an NGO subcontracted from CNWL). The same podiatrist covers all four of the public sector prisons in Surrey. She considers that the one session per month currently committed to HMP Coldingley is insufficient to meet the need there, and this should be increased to a day per month. Healthcare also thinks the provision needs to be increased, ideally to two separate half-days so as to reduce waits for the more urgent cases. The provision is in the process of being reviewed. There are no cover arrangements, and these have not been necessary so far.

Recommendation 6 – Review the podiatry provision for HMP Coldingley.

The service, since covid-19, has been limited to emergencies; lately to emergencies and acute cases. Additionally, during the pandemic only one prison can be visited in the one day. As a result of this, waiting lists have built up considerably. These waits can be brought down again by deploying extra sessions, although it is not always easy to deliver these.

The podiatrist can access SystmOne off-site and triages her own referrals and manages her own list. She noted that referrals were often of poor quality, though some education with primary care staff may help with this. The podiatrist would like there to be a nurse trained in diabetic foot checks in each prison and it is part of her role to educate and train other healthcare staff.

Recommendation 7 – Develop podiatry education and training across the Surrey prisons.

The majority of appointments are assessments and/or one-off treatments. There are four main areas of work:

1. High risk wound care, e.g. ulcers, etc.
2. Musculoskeletal
3. Core foot protection
4. Nail surgery (acute)

The podiatrist noted that problems with stock ordering sometimes meant she was unable to deliver planned interventions, e.g. because of lack of in-date local anaesthetic or surgical tools. Secondary referrals are relatively unusual, although can be serious.

3.10 Pharmacy and Medicines Management

3.10.1 Overview

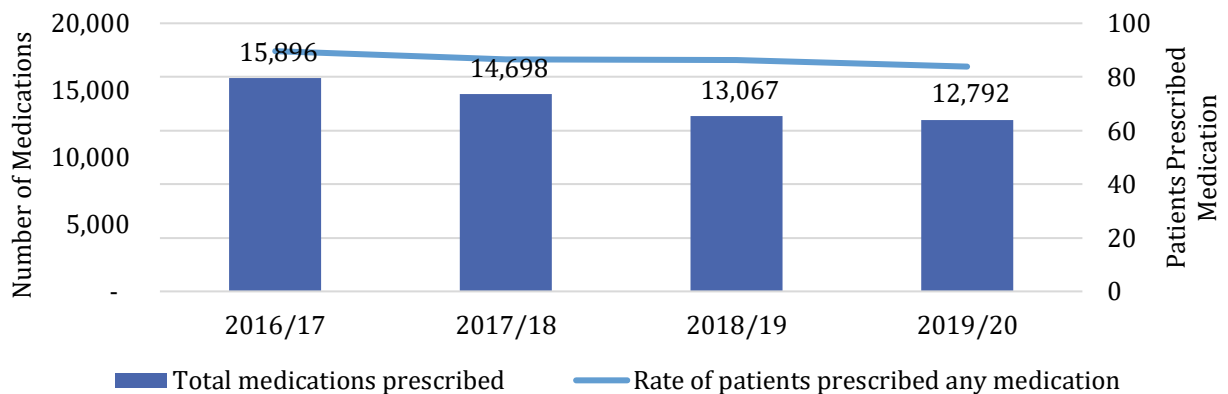
The main pharmacy is at HMP/YOI High Down and serves the four public sector Surrey prisons. It was designed and built as a pharmacy and is well-equipped and fit for purpose. The pharmacy hours there are office hours Monday to Friday plus Saturday mornings, although the Saturday morning is essentially for admissions to HMP/YOI High Down. Any urgent prescriptions received before 10.30 on a weekday will usually be back with the sending prison that day, otherwise they are usually the following working day.

There is a good level of pharmacy staffing across Surrey. The 8b pharmacy lead covers the county. The pharmacy is well established and well regarded. The pharmacy staff liaise with the prescribers and healthcare and ensure safety and governance with regards to medicines management.

HMP Coldingley has 0.2 of the lead pharmacist and 0.2 of a band 5. This is just about sufficient as the need is less than elsewhere as it is a working prison with largely healthy residents, so less medicines are used than at other prisons. Additionally, all administration of medicines is normally from healthcare which makes it easier for the primary care staff who do the administration. Substance misuse service administration is done by the SMS staff from a separate dispensary on one of the wings.

Prescribing data from SystemOne shows little overall change in the numbers of medications prescribed at HMP Coldingley over the past four years. However, the population seems to have reduced gradually over the same timescale, such that the rate of patients receiving any prescribed medication has changed little.

Figure 33 – Total Prescribing (SystemOne data)



3.10.2 Administration of Medicines at HMP Coldingley

Prior to covid-19, most administration of medicines was from healthcare, and most residents got themselves there. The pharmacist felt medicines queues were not always properly supervised by prison staff. Security was also concerned about the risk of diversion of controlled drugs, though felt that the SMS queue is properly supervised.

The approach under covid-19 is now wing-based. Pairs of nurses cover two wings each and, escorted by officers (for safety, and as nurses don't have cell keys), they administer through

the cell door. This is also an opportunity to talk to the resident about any concerns, and staff report identifying a lot of need this way.

3.10.3 Pain Control

HMP Coldingley has an analgesic review clinic (ARC) involving the GP and a pharmacist. This can involve physiotherapy referrals (see [above](#)) and referrals to the secondary care pain specialists if necessary. This is held every two weeks at HMP Coldingley. DNAs are common as patients try to avoid having their medications reviewed. The practice to manage this avoidance is a warning the first time and then the patient’s medicines are reduced if they continue to avoid appointments. These clinics have worked well in reviewing pain-control prescribing and reducing the amount of tradable medicines. These are not core business in existing service specifications but should be in the future. They have currently ceased under covid-19. Amongst the comments for our patient surveys were several complaining about the reduction or cessation of pain-control medication.

Recommendation 8 – Embed the analgesic review clinics into the healthcare provision in all the Surrey prisons.

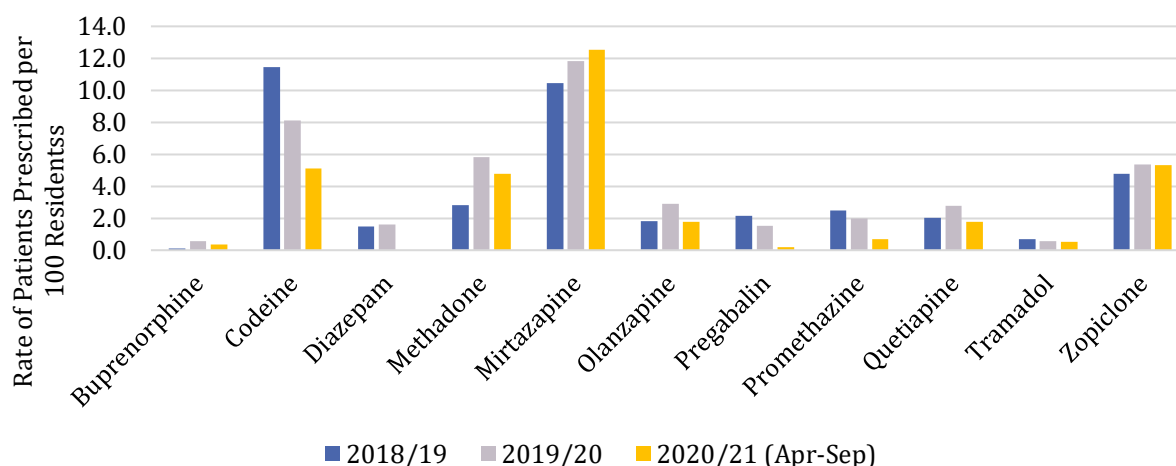
Some of the staff said that they would like to see more provision for non-medical pain management interventions and support for sleep, e.g. a sleep clinic, acupuncture, etc.

Recommendation 9 – Further develop non-medical approaches to pain-management and sleep.

3.10.4 Tradable Medicines

SystmOne shows an increase in the rate of patients prescribed mirtazapine, while the rates of prescribing of some other potentially tradable medications (most notably codeine) have reduced. Mental health reports that the rising levels of mirtazapine are partially due to it being used to help support sleep as well as an anti-depressant.

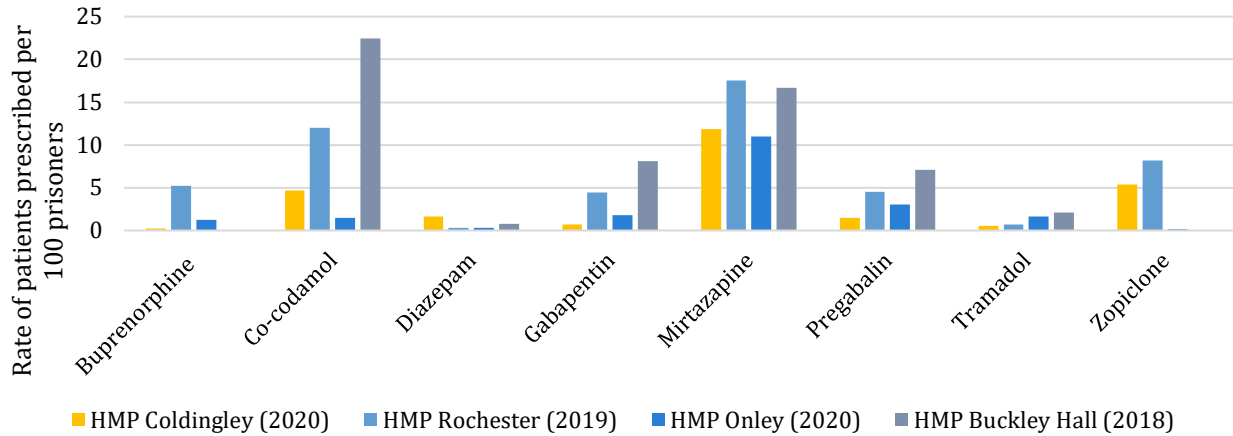
Figure 34 – Rates of Prescribing of Tradable Medications



The GP reported that they had nearly stopped prescribing pregabalin altogether (just one person) and considerably reduced the use of co-codamol.

For context, the chart below compares the prescribing rate for 2019/20 against recent prescribing rates of some potentially tradable medications in comparator prisons for which this data was available (for the most recent full year at the time of data collection; note data on buprenorphine and zopiclone was not available for HMP Buckley Hall). HMP Coldingley appears to have a relatively low prescribing rate of many potentially tradable medications.

Figure 35 – Tradable Medications Comparison



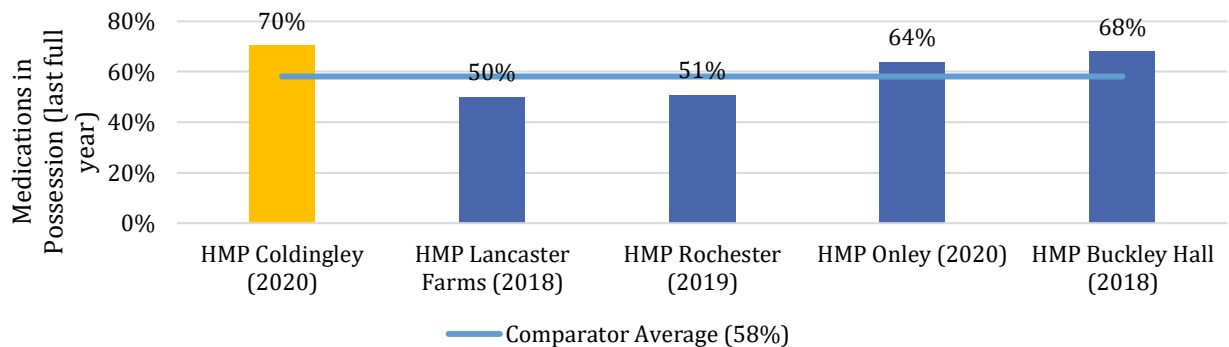
3.10.5 In-Person Possession

In-person possession is considered good practice (within safe limits) as it increases autonomy and treatment engagement. It has become particularly important during covid-19 as it reduces the need for the interaction and possible transmission of infection involved in the administration of medicines. Pharmacy works closely with primary care on this, and helps with compliance checks, etc.

Data from Health and Justice Indicators of Performance (HJIP) reporting indicates that during 2019/20, on average, 97% of new receptions each month were assessed for suitability for in-possession (IP) medication at HMP Coldingley. In 2020/21 to date, this rose to 100% of new receptions. An average of 98% of existing patients in 2019/20 (who had been in the prison for at least 30 days) also had an assessment each month (this stayed consistent in 2020/21 at 97%). SystmOne data showed a similarly high proportion, with 99% of current patients at a snapshot in October 2020, having an in-possession risk assessment on record.

Not all patients are assessed as suitable for IP and not all medication can be administered IP. The actual rate of in-possession prescribing (the percentage of issued medications that were recorded as in-possession during 2019/20) was 70% according to SystmOne data, which is above average among comparators for which this information was available.

Figure 36 – Medication Prescribed In-Possession (SystmOne data)



In short, HMP Coldingley already had high levels of in-person possession before covid-19 and this will have helped reduce the risk of infection.

3.10.6 Homely Remedies

There is quite a wide selection of homely remedies, including ten for minor ailments. Examples are: ibuprofen, paracetamol, deep heat, bonjela, antacid tablets, dioralyte sachets to replace electrolytes, etc.

3.10.7 Release

Residents being released into the community are offered a discharge clinic several weeks prior to their release date and plans are made for ensuring regularly prescribed medicines are prescribed to take out (or FP10s (signed prescriptions) if indicated). There used to generally be seven days' medicine on release, since covid-19 this can be for up to 28 days. Looking at to take out (TTO) medication, HJIP data showed that of patients leaving HMP Coldingley during 2019/20 while in receipt of prescribed medication, an average of 57% of those discharged (71 of 139 patients) were given at least a week's medication. This increased to 74% of eligible patients during June to September 2020 (data for April and May was not available). Transfers to other prisons will usually be given at least a week's medication.

3.11 Chapter Summary

- Healthcare services at HMP Coldingley are generally well-regarded by staff and residents.
- Healthcare is provided 7:30am to 6:30pm Monday to Friday, 7:30am to 5:30pm at weekends. There are no in-patient beds.
- Primary care and GP staffing levels appear adequate.
- Healthcare service user feedback is generally positive.
- There are structured processes in place to ensure user engagement and consultation.
- The healthcare delivery model has changed under covid-19 from centralised to being wing-based where possible. Some elements of this may be worth keeping post-covid-19 (see **Recommendation 2**).
- Core on-site healthcare services have functioned well despite covid-19 restrictions.
- There is an appropriate range of clinics and these are effectively run. Waits and DNAs are (normally) mostly within acceptable limits.
- Provision from the various in-reach services has been significantly impacted by covid-19 and there are large and growing waiting lists.
- Telemedicine has been invaluable during covid-19 and will continue to help with secondary care, enhancing care and reducing costs and the need for escorts.
- Emergency codes are infrequent though not clearly recorded on SystmOne (see **Recommendation 3**).

- The 'extra' third dental session needs to be made permanent and optional extra sessions made available to clear the large covid-19 backlog and ensure future waits are kept to acceptable limits (see **Recommendation 4**).
- Physiotherapy sessions need to be increased and the backlog dealt with (see **Recommendation 5**).
- Podiatry sessions need to be increased and the backlog dealt with (see **Recommendation 6**).
- Some podiatry training for primary care could help enhance diabetic care (see **Recommendation 7**).
- Medicines management and governance are well established.
- The analgesic review clinics have helped reduce the use and misuse of tradable drugs (see **Recommendation 8**) and there are low rates of tradable prescribing.
- Further development of non-medical support for pain control and sleep could further reduce the use of tradable medicines (see **Recommendation 9**).
- There are high rates of in-person possession.
- Where necessary releases and transfers are provided with at least a week's supply of medication.

Chapter Four – Physical Health

4.1 Long-Term and Chronic Conditions (LTCs)

Throughout this chapter, we have estimated the expected prevalence for each condition specifically for HMP Coldingley, weighted for the age profile of the current prison population. The separate Part B report includes more general background context, prevalence estimates and commentary on methodology, including age-weighted estimates.

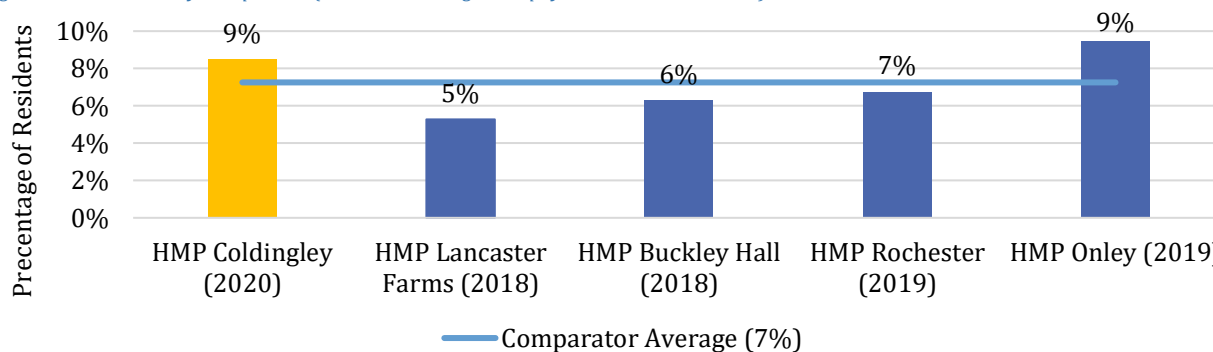
There is a strong correlation between LTCs and both increasing age and social deprivation. As noted in [Chapter Two](#), the age profile in HMP Coldingley is dissimilar to the national average for prison residents, having a higher rate of 30-39 year olds and 50-59 year old residents.

In wider society, compared to the highest social class, those in the lowest social class have a 60% higher prevalence of LTCs and a 30% higher severity of conditions.²⁶ Typically, disproportionate numbers of prisoners are drawn from the most deprived areas.

4.2 Comorbidity

The recorded prevalence of comorbid physical health conditions at HMP Coldingley is slightly higher than most comparator prisons for which data was available. Considering the age profile, this may indicate better identification of long-term conditions than comparators rather than a greater prevalence.

Figure 37 – Comorbidity Comparison (two or more long-term physical health conditions)



4.3 Asthma

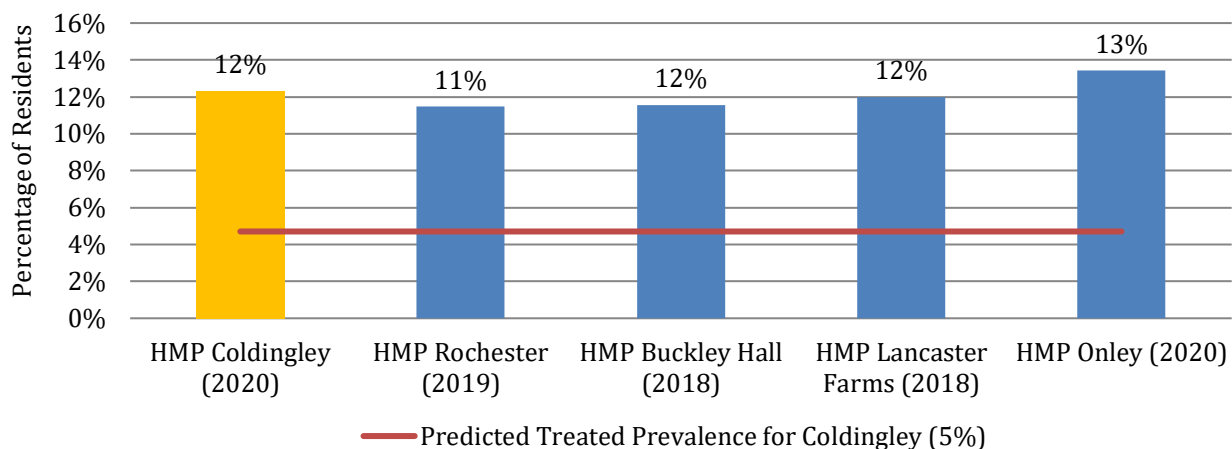
The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

Based on the age-related prevalence of asthma and the current snapshot population, we would expect to see 52 men (12%) diagnosed with asthma, and 21 men (5%) treated. Both the diagnosed and treated rate are considerably higher in HMP Coldingley than would be expected, with 85 (19%) having a recorded diagnosis and 55 (12%) on the Quality and Outcomes Framework (QOF) register as being currently treated. This suggests that the use of QOF and the approach to long-term disease management are effective, though primary care

²⁶ Department of Health (2012). Report. [Long Term Conditions Compendium of Information: Third Edition](#).

felt that not all the asthma recorded on SystemOne may involve an asthma diagnosis. Due to changes in QOF data, we cannot compare this to the rate of identification pre-covid-19. The disparity between the diagnosed and treated numbers is likely due to historical diagnoses which have not been removed from SystemOne.

Figure 38 – Asthma Prevalence Comparison (QOF data)



The rate of treated asthma in HMP Coldingley is average among comparator prisons.

Asthma is usually dealt with in the general nurse clinic. One of the nurses is trained to do asthma reviews and there is an agency band 4 who primary care calls on when more reviews need doing. There is no lead overseeing monitoring and care as numbers are low (see [Recommendation 10](#) below). Needs in this area appear to be met.

4.4 Chronic Obstructive Pulmonary Disease (COPD)

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

Based on the age-related prevalence of COPD and the current snapshot population, the predicted estimate for the number of men in HMP Coldingley identified with COPD was 2.0% (nine patients). At the October 2020 snapshot, there were fewer than five men (<1.2% of the population) with a recorded diagnosis on SystemOne, not all of whom were on the QOF register as being treated for the condition. Due to changes in QOF data we cannot compare this to the identified prevalence prior to covid-19. Rates of COPD were typically higher in comparator prisons, with an average of 1.8% on the QOF register across four comparators.

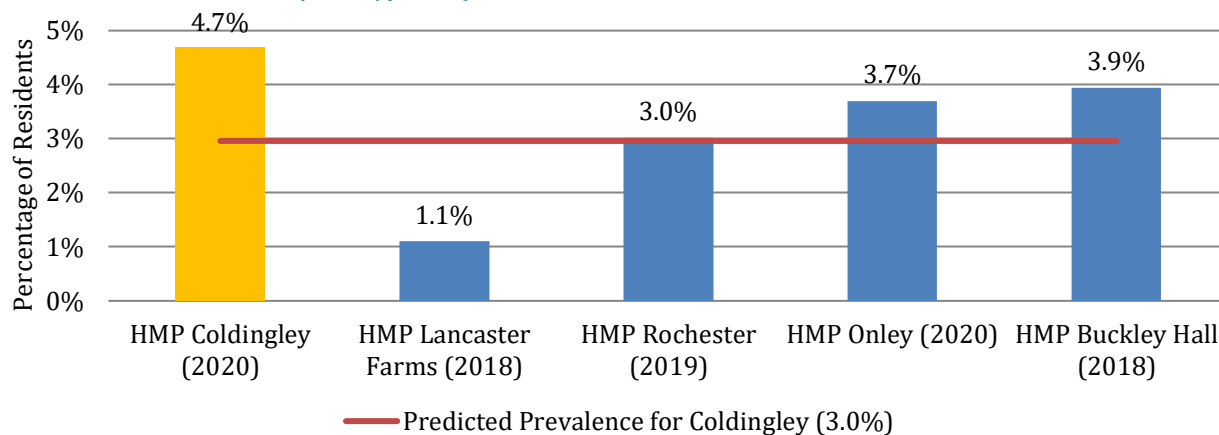
Low numbers such as these are vulnerable to bias effects, but it still appears that COPD may be lower than expected. A possible explanation is that COPD would at times act against a transfer to a working prison, although this is impossible to measure. The effectiveness at identifying and treating asthma gives some confidence that COPD pathways are probably effective too, and we conclude that need is partially met.

4.5 Diabetes

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

The rate of diabetes is increasing rapidly in society at large, meaning that actual rates frequently exceed predictions. The predicted prevalence of diabetes, based on age-specific prevalence data and the current age profile of residents at HMP Coldingley, is 13 men (3.0% of the population). The 5.1% identified (n=23) and 4.7% treated (n=21) are above the predicted prevalence.

Figure 39 – Diabetes Prevalence Comparison (QOF data)



Diabetes prevalence is higher than all comparators. The prevalence at our October snapshot seems to be fairly typical for HMP Coldingley – during a more ‘normal’ period (between October 2019 and March 2020) there was an average of 4.3% (18 men) on the QOF register.²⁷

Patients are booked into the nurse clinics as required. One of the nurses is a trained diabetic nurse and one of the GPs also specialises in this area. This expertise may explain why HMP Coldingley appears to be so good at identifying and engaging patients with diabetes. The table in [section 8.4](#) shows a relatively high level of diabetic risk screening and reinforces the previous conclusion. There is no reason to think that the HMP Coldingley population is likely to be more prone to diabetes than comparator populations.

Needs appear to be met.

4.6 Epilepsy

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

Identified rates of epilepsy are very similar to the predicted prevalence, with 1.3% of the population (six men) treated for epilepsy, compared to 1.2% (five men) predicted. This is lower than comparator establishments, though small numbers such as these are subject to fluctuation.

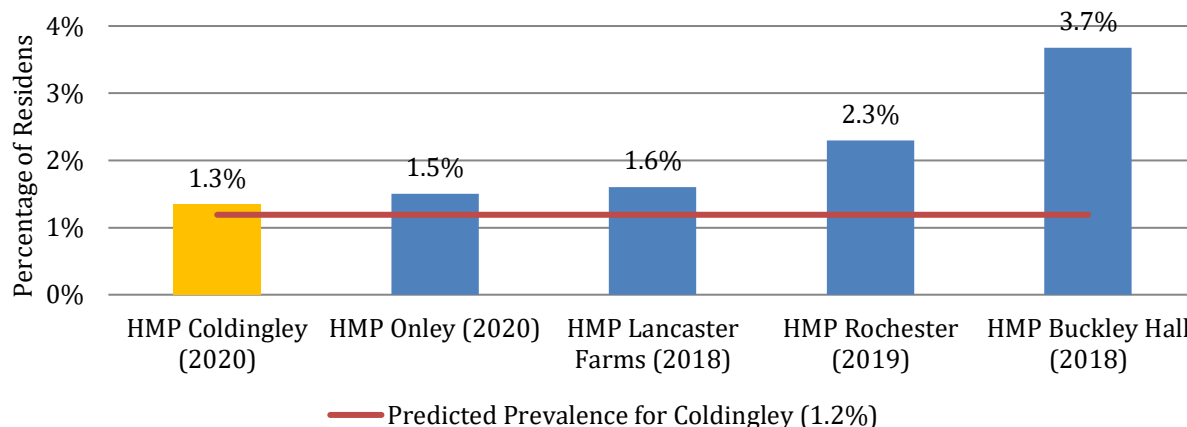
The prevalence at our October snapshot seems typical, with an average of 1.2% (five patients) on the QOF register between October 2019 and March 2020.²⁸ The figures used refer to those on the QOF register as being prescribed medication for epilepsy and thus should only include cases that have been medically verified (and will exclude those who are prescribed anti-seizure medication for unrelated conditions e.g. bipolar). There is a much higher number of

²⁷ Number on QOF register is based on historical QOF ‘How Am I Driving’ data; average population is based on MOJ-reported population at the end of each month from monthly [Prison Population Figures](#). (checked December 2020).

²⁸ *Ibid.*

residents (equal to 3.6% of the population) recorded on SystmOne as having an epilepsy diagnosis (not necessarily current or confirmed).

Figure 40 – Epilepsy Prevalence Comparison (QOF data)



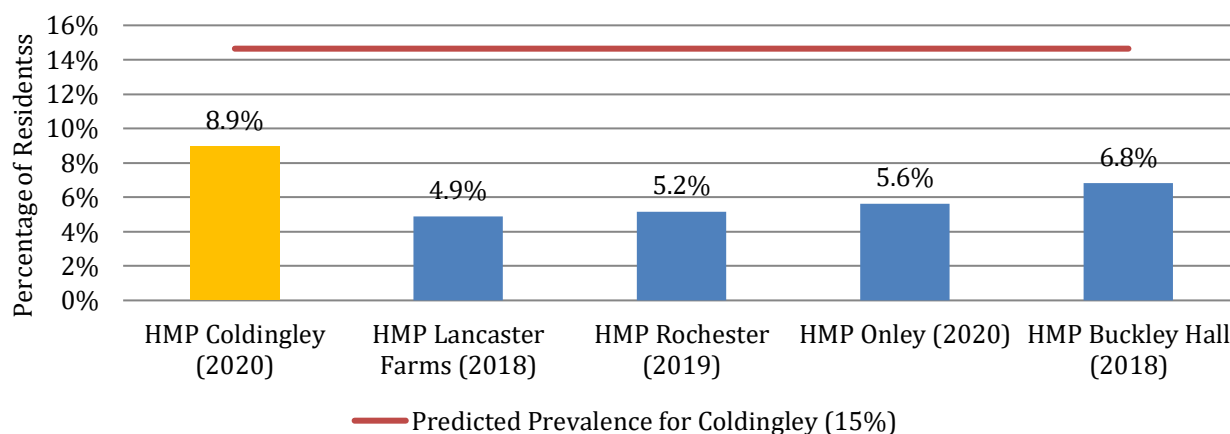
Patients are booked into the nurse clinic as required. Need is likely being met.

4.7 Hypertension and Coronary Heart Disease (CHD)

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

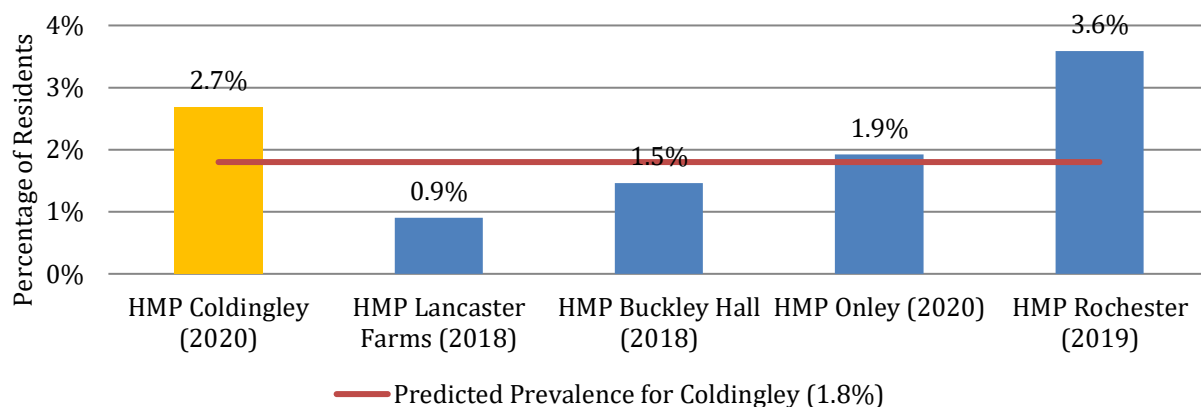
The identification rate for hypertension is below the expected prevalence based on the population age profile – we would expect 65 men with hypertension (14.6%), while only 46 (10.3%) were diagnosed and 40 (8.9%) were on the QOF register as currently treated. This is, however, higher than all comparators.

Figure 41 – Hypertension Prevalence Comparison (QOF data)



Identification for CHD, on the other hand, is a little above the predicted rate, with 2.9% of the population (13 men) diagnosed and 2.7% (12 men) treated, compared to the predicted 1.8% (eight men). The proportion of residents treated for CHD is higher than most comparators.

Figure 42 – CHD Prevalence Comparison (QOF data)



The prevalence of hypertension at our October snapshot may be slightly lower than is typical for HMP Coldingley – during a more ‘normal’ period (between October 2019 and March 2020) an average of 9.7% of the population (41 patients on average) were recorded as being on the QOF register.²⁹ For CHD, identification at our snapshot seems more typical (2.2% or nine patients on average between October 2019 and March 2020).

The table in [section 8.4](#) shows SystmOne numbers for hypertension screening similar to the numbers in the prison, i.e. suggesting a high level of screening. Hypertension would normally be picked up on the reception screen, but later occurrences may not be so easily picked up outside of the regular health checks for certain groups or conditions. More routine measuring of blood pressure of the general population may help with this, e.g. as part of any triage and as a feature of wellbeing days or men’s health events. CHD would primarily be managed by the GP and through the nurse clinic.

We conclude that some hypertension may be being missed, though CHD is largely being identified and the needs met.

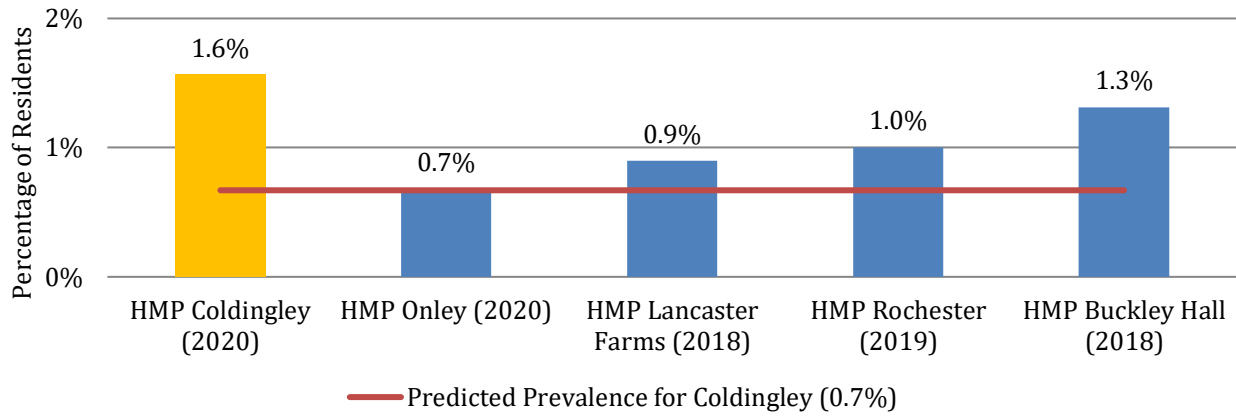
4.8 Cancer

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

As of October 2020, there were seven men in HMP Coldingley on the QOF register for cancer, equating to less than 1.6% of the population (this does not seem unusual for the prison, with an average of 1.3% of the population identified with cancer between October 2019 and March 2020). This is higher than the expected prevalence (0.7% or five men) based on current evidence. Cancer prevalence is higher than all comparators. However, with such small numbers it is not advisable to draw firm conclusions about the prevalence of cancer at HMP Coldingley, other than to say that this suggests need is largely identified and met. Cancer patients will be managed by the GP and seen in GP and nurse clinics.

²⁹ Number on QOF register is based on historical QOF ‘How Am I Driving’ data; average population is based on MOJ-reported population at the end of each month from monthly [Prison Population Figures](#). (checked December 2020).

Figure 43 – Cancer Prevalence Comparison (QOF data)



4.9 Sickle Cell Disease and Haemophilia

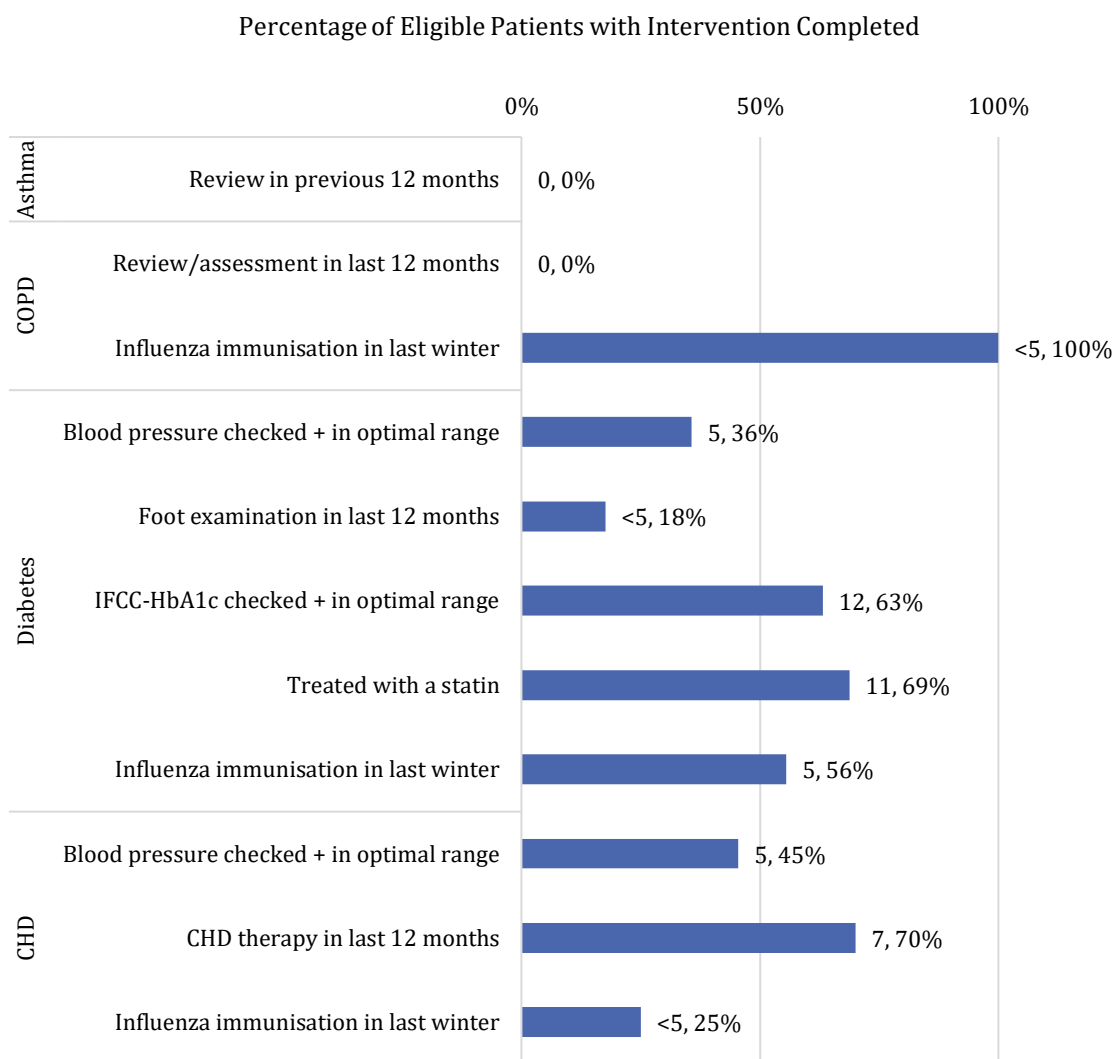
Part B describes sickle cell and possible interventions. At a October 2020 snapshot, SystmOne reports eight patients with a record indicating they have sickle cell or are a carrier, equivalent to 1.8% of the population. Healthcare reports that only two of those eight people have sickle cell (and are shielding) and the other six are carriers.

Healthcare also reports that there are less than five haemophiliacs at HMP Coldingley.

4.10 Management of LTCs

The chart below is based on the 'How Am I Driving' QOF report, which states the number of patients eligible for various interventions, related to the management of health conditions (such as patient reviews and diabetic foot checks), and then numbers for whom a record of these interventions exists on SystmOne. A selection of relevant indicators is shown for each condition. Note that some men with long-term conditions may not be in the prison long enough to be due a review during their time at HMP Coldingley. Many of those with long term conditions will have had these identified at first reception screening in previous establishments and may have had a review undertaken there.

Figure 44 – Eligible Patients with LTC Management Interventions Completed (QOF data)



It should be noted that the long time period over which some of these indicators are tracked (usually 12 months) means that some patients will have been in a different prison for some of that time. However, the data above reflects activity at the current prison only, since if a patient has an intervention recorded at a previous establishment, they will not be considered eligible at the current prison. Full data and explanations of each indicator can be found in [Appendix B](#).

We discussed some of the above figures with CNWL’s performance lead. Changes in the QOF monitoring account for the apparent lack of asthma reviews. We were provided with figures from the previous year and these showed 20 out of 23 eligible patients as having been reviewed, i.e. the need was largely been met for asthma monitoring and review. COPD numbers were low so subject to bias, but showed very low numbers of patients (one or two) missing the measured interventions. COPD monitoring and other interventions were at least partially happening, if not largely.

The diabetes blood pressure is considered to be largely a problem with record-keeping, as separate readings need to be noted together so stability can be established. The performance lead is working with the nurses on this point. The foot examinations are discussed in [Podiatry](#). The numbers are low and vulnerable to bias but may reflect difficulties with reviews under covid-19.

Overall, the rate of flu vaccination for at risk groups appears low. Healthcare reports that some men refuse and note these are still counted as eligible, i.e. monitoring is not sophisticated enough to show the difference between a refusal and the lack of an offer. Nevertheless, we feel some may be being missed.

None of the long-term conditions occur in large enough numbers to warrant there being a lead or specialist nurse allocated specifically to that condition to ensure monitoring and care, however, the same responsibility can sit across all LTCs and be more justifiable. Such a post could oversee all the treatment plans for the LTC patients and ensure all the necessary reviews and monitoring. Primary care is considering further developing such a role, although there is some concern that this risks de-skilling other staff. There is a slight risk of this, but we think the benefits likely outweigh the risks, particularly in a relatively small team where some cross-cover is inevitable, and communication is good. Additionally, a specialist post may bring expertise into the team to be shared. The GP oversees some of the LTCs, e.g. cancer, but would like to have more time to spend on LTCs in general.

Recommendation 10: Develop lead responsibility for oversight of long-term conditions.

Most of the LTCs are involved in key performance indicators and are closely monitored by CNWL's performance lead who ensures any reviews, etc. are flagged up. The record-keeping involved does not seem to always reflect activity or outcome.

Our overall conclusion is that there are relatively strong pathways for the LTCs, and it is likely that most need is being identified and met, though there could be some improvement in monitoring.

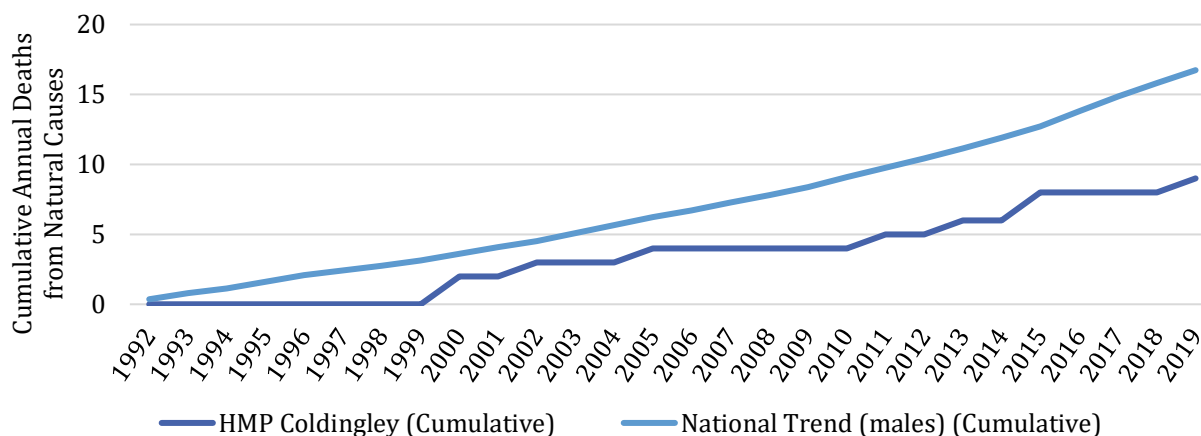
4.11 End of Life and Palliative Care

At an October 2020 snapshot, there were no men on the palliative care QOF register at HMP Coldingley. The lack of 24-hour nursing care at the prison means it is unlikely there ever would be a need for palliative care. Any such emergent need would trigger a transfer to somewhere with 24-hour care, and possibly into an inpatient unit.

4.12 Deaths from Natural Causes

As can be seen in the chart below, the national trend is for an increasing number of deaths from natural causes (as denoted by the line growing steeper). The 'national trend' line is standardised to the prison's op cap and describes the number of deaths that would have occurred in a population the size of HMP Coldingley if it followed the national trend. There have been five reported deaths from natural causes at HMP Coldingley in the last ten years. This is lower than the national trend.

Figure 45 – Deaths from Natural Causes (1992-2019)- cumulative



There has been one death from natural causes reported³⁰ by the Prisons and Probation Ombudsman (PPO) in the past two years. There were no recommendations pertaining to healthcare. There have been no deaths by natural causes since this one, although there has been an unexpected death where the investigation has yet to be published, outlined in [Chapter Six](#).

4.13 Chapter Summary

- Nine per cent of patients have two or more recorded long-term physical health conditions, higher than most comparator establishments.
- Prevalence of asthma is high above the predicted rate, whereas COPD is below predicted.
- Prevalence of diabetes is higher than expected and higher than comparators.
- Prevalence of hypertension is lower than predicted though above comparators, prevalence of CHD is above both.
- Prevalence of cancer is higher than expected.
- Management of LTCs is generally good, though monitoring could be improved and increased oversight would help (see **Recommendation 10**).

³⁰ HMIP (2020) [Independent investigation into the death of KJ a prisoner at HMP Coldingley June 2019](#) (accessed December 2020).

Chapter Five – Mental Health

5.1 Service Provision

Central and North West London NHS Foundation Trust (CNWL) is the commissioned provider of secondary mental health care in the establishment. Primary mental health is not specifically commissioned, though clinically is largely covered by the GP. There is a range of other provision for emotional support such as the chaplaincy and listeners.

5.1.1 Service Model

CNWL's model of mental health provision across its services – including the other Surrey prisons - is a stepped-care pyramid model of four steps with increasing complexity, need and risk the higher up the pyramid the person is. Targeted and specialist mental health input is focused on the top three levels (level 1 is self-help). The small mental health service at HMP Coldingley covers levels 2-4, largely focused on the third step, that of 'traditional' secondary mental health, the kinds of conditions that have clear diagnoses, that are managed by medical interventions, and that would be under the care programme approach in the community, e.g. severe and enduring depression or psychotic illnesses. This focus on secondary mental health, together with the small resource, mean the team is often 'fire-fighting' and can struggle to be more proactive in pre-empting worsening health, and promoting better health and wellbeing across the full range of need. The most severe problems do not occur often at HMP Coldingley as those with these conditions would not be considered appropriate for a working prison in the first place, or would need a level of care and supervision that could not easily be provided there.

What service there is, is well regarded. Everyone we spoke to, however, felt that mental health was by far the biggest gap in healthcare provision at HMP Coldingley. Mental health and other staff are aware of the gaps and do their best to cover these, but do not have the resources to adequately do so. Some staff we spoke to felt that this obliged mental health to overly rely on medications to address people's problems, when psychosocial and psychological responses may have been more appropriate and more productive in the long run. This is all discussed in more detail throughout this chapter.

Our conclusion is that there is a need for an appropriately resourced model of mental health provision that matches the need at HMP Coldingley, i.e. there are interventions and pathways appropriate to each of the levels of need. Our understanding is that NHS England and NHS Improvement is currently pursuing a business case for enhanced mental health resources for Surrey as a whole, so hopefully this will help address at least some of this unmet need. More detailed recommendations in this respect are throughout the chapter.

Recommendation 11: The model of mental health provision at HMP Coldingley needs to be reviewed and resourced so as to respond to the full range of needs.

The staffing model at HMP Coldingley has developed in a piecemeal way as the more pressing needs have been identified and, to a limited extent, resourced. It is essentially a small secondary care in-reach team (though prison-based) with an even smaller psychology component, focused on elements of the care of the more complex on the one hand, and very limited support for primary mental health concerns on the other. The psychology 'team' manages its own referrals and caseload. In any revised model it should be more integrated

into the mental health structure in managerial and service terms at least (whilst still receiving clinical supervision within the psychology structure).

Recommendation 12: Fully integrate psychology into the mental health team.

5.1.2 Working Hours

In HMP Coldingley, the service currently operates five days a week, from 8:00am to 4:00pm. At the end of 2020 CNWL introduced a new cross-Surrey system of on-call cover 10-4 on weekends and public holidays to address urgent mental health concerns. This was primarily telephone triage with the possible option of on-site attendance if necessary. This largely meets the NHS England requirements for a service which operates into the evenings and seven day per week.³¹ Mental health and primary care felt the hours were adequate. Some of the prison governors felt weekend cover would be desirable but recognised it would be difficult within the existing small resource. Note that primary care covers the weekend so can provide some level of screening/advice.

5.1.3 Staffing

The table below outlines the mental health staffing complement for HMP Coldingley.

Figure 46 – Mental Health Team Staffing HMP Coldingley

Role	Band (or equivalent)	Full-time Equivalents	Issues
Mental health service lead	8a	1.0	Functions as advanced nurse prescriber (ANP), provides cover in absence of psychiatrist as NMP.
Care coordinator	6	1.0	Focused on severe and enduring cases under CPA.
Associate practitioner	4	0.6	Additional 0.4 worked in primary care.
Learning disabilities nurse specialist	7	0.2	Shared with 4 other sites.
Consultant psychiatrist	Consultant	0.2	Shared with another site.
Consultant clinical psychologist	8c	0.2	Vacant
CBT psychologist	7	0.4	1 day per week at university.
Counsellor	6	0.2	
Assistant psychologist	4	1.0	Vacant, was covered with 0.2 bank but unable due to covid-19. Not supervised by psychology on a daily basis. Isolated role and post.

Notable is a complete lack of ‘normal’ mental health nurses (RMNs), e.g. band 5 and band 6 RMNs in the mental health team. This is unusual, as in most prisons it is these nurses who will provide the bulk of the mental health interventions, although they can be hard to recruit and retain.

Recommendation 13: Increase the mental health nursing provision.

The band 4 associate practitioner ensures the annual physical health checks for the mental health patients.

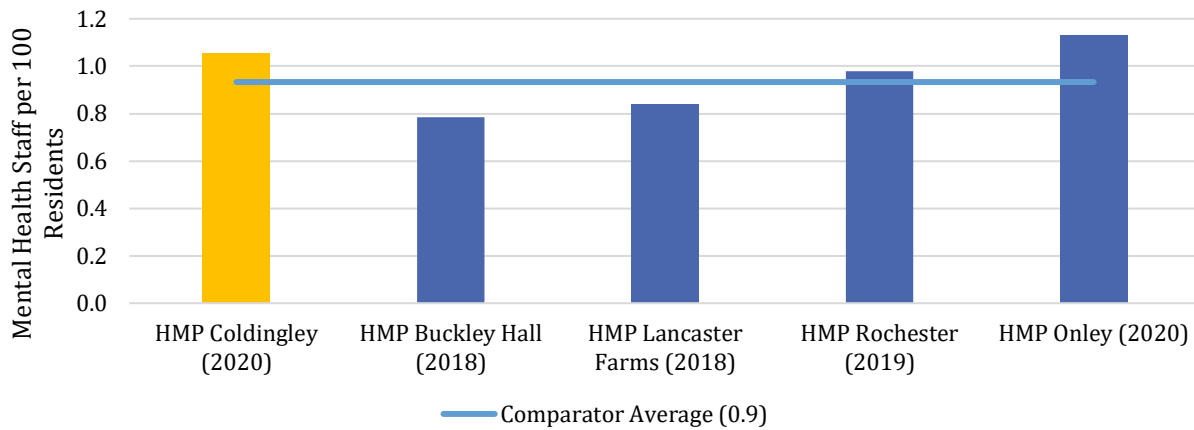
³¹ NHS England (2018) [Service specification: Integrated mental health service for prisons in England](#). (checked December 2020).

The Samaritans support a team of peer listeners who are available throughout the wings, although covid-19 has prevented them from working on wings other than their own. The chaplaincy also offers a range of support, including on defined areas such as bereavement.

The psychology and psychiatry components are discussed in the next section.

The following is gathered from recent HSCNAs of comparator prisons where data is available; whilst it should be read with caution as prisons describe mental health teams differently, the team appears to be relatively well-resourced in terms of staffing provision. The consistent view of everyone we spoke to was that the mental health team was not well resourced, and as will be seen from the discussion of the various gaps in provision throughout this chapter, the chart below is probably more of a reflection on the poor state of mental health provision across the comparators as well.

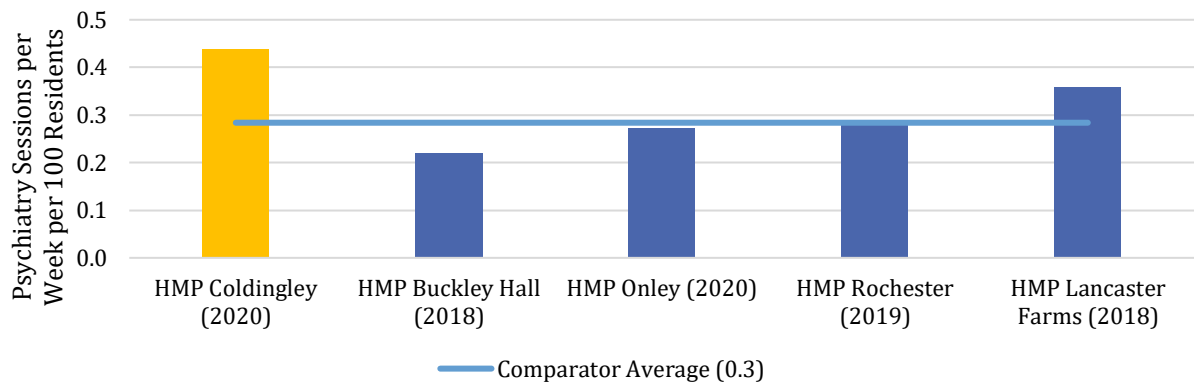
Figure 47 – Staffing HMP Coldingley and Similar Prisons



5.1.4 Psychiatry and Psychology

There are currently two psychiatry sessions per week provided by a consultant psychiatrist (who also covers HMP Bronzefield, HMP Send and HMP High Down). The mental health service lead can cover some of the psychiatrist’s role when necessary. There is also long-arm psychiatrist cover from within CNWL. This level of psychiatrist cover (per 100 men, based on the current op cap of 456) is high relative to comparators and mental health agrees that it is adequate.

Figure 48 – Psychiatrist Provision Comparison



There is little guidance about the number of staff a mental health team should have, but a 2007 benchmark is the Royal College of Psychiatrists (RCPsych) guidance.³² Applying its formula to HMP Coldingley, it recommends 0.3 FTE consultant psychiatrist for a prison of this size and category. Being dated, this publication does not take account of the enhanced nursing and other roles now available.

Psychological therapies are aimed at step four in the stepped-care model, i.e. the most complex, comorbidity, trauma and personality disorder. Many of the more complex patients would be unlikely to be sent to HMP Coldingley in the first place, although there is still a need at the prison, and due to the long-term nature of the interventions and the small nature of the resource, a largely unmet need and a matter for concern for both healthcare and prison staff. Psychology often did not have the time to input to sentence plans, parole hearings, etc. HMP Coldingley could benefit from more of a qualified psychological therapist to provide assessments and long-term interventions, as well as the supervision and leadership of the other psychologists. This should be an increase to two days per week at minimum.

The prison was keen for more interventions focused on the offending personality disorder pathway and for offender behaviour programmes and courses in general, although these would normally be mostly an HMPPS commissioning concern rather than a healthcare one.

Counselling and cognitive behavioural therapy (CBT) sit under psychology, and also have long waits and considerable unmet need. The step two IAPT (improving access to psychological therapy) type CBT provision is usually delivered in groups, ideally co-facilitated. More assistant psychologist time would help address the unmet need for IAPT-type provision. Current staffing is such that the IAPT provision is almost non-existent.

The psychology team is made up of small contributions from several staff with differing roles and cannot easily be considered a team in the practical sense. It is clear that the psychology resource needs to be increased if it is to meet need, and hopefully this would allow for a more defined team, although we believe this should in turn be properly integrated within an also-enhanced mental health team.

Recommendation 14: Increase the provision for tier 2 and tier 4 interventions.

5.2 Access and Waiting Times

5.2.1 Identifying Mental Health Need

Many severe and enduring mental health concerns would exclude the person from a transfer to HMP Coldingley, but where this is not the case, then the services in the previous prison may have made contact with HMP Coldingley and passed on relevant information. This is reported to be variable in quality. Additionally to this, healthcare staff try and establish any presenting needs of impending receptions through SystmOne, though cannot access all patients' records.

The early days custody screen is carried out in reception, as is the initial health screen, and these establish most existing mental health concerns. This is a relatively recent development that mental health reports as increasing the numbers picked up at reception. Other mental health concerns may arise during the person's stay, although these are usually primary rather than secondary mental health issues.

³² RCPsych (2007) [Prison psychiatry: adult prisons in England and Wales](#). (accessed December 2020).

Since covid-19, mental health has been developing ‘drop-in’ type clinics, i.e. they go on the wings and see if anyone wants to see them and try and respond to the presenting need, through advice, signposting, onward referral, follow up appointments, etc. This is popular with residents and has also led to a decrease in formal appointments as it supports pre-emptive mental health promotion, allows the opportunity to triage, and more appropriately divert some enquiries, and allows mental health staff to satisfactorily respond to some concerns such that no further action is needed at that point. There are currently plans to try and continue this low threshold access post-covid-19. The impact of covid-19 has increased the likelihood of presentations later in a person’s stay, although not to the extent to which many staff originally feared. Some provision has changed during covid-19, e.g. groups have had to be stopped or significantly changed in format.

The medical needs of primary mental health concerns are usually addressed by the GP, e.g. the continuation or review of a course of anti-depressants. Any psychosocial needs are addressed by a referral to the psychology team. This would be for short IAPT-type interventions, or in some cases for longer-term counselling. There are waits for both, particularly the latter. Needs for counselling may not be mental health in the commonly used sense, e.g. a bereavement may prompt a resident to seek support and counselling. The chaplaincy can provide some talking therapy type support, as to some extent can the peer-support listeners, although both are currently limited or stopped altogether under covid-19. It is worth noting in this context that many of the ‘social prescribing’ options that might normally be encouraged are restricted under covid-19, for example, socialising, exercise, and fresh air.

Recommendation 15: Further develop pathways for psychosocial responses to primary mental health needs and resource these accordingly, including for longer-term emotional support and counselling.

The SystemOne waiting lists and appointment ledgers for mental health appointments indicated a wait time of 32 days to access therapy with CNWL; there were no patients currently waiting to see a psychiatrist at the time of our snapshot in October 2020.

5.2.2 Did Not Attend (DNA) Rates

SystemOne data showed the following clinic occupancy and DNA rates for mental health clinics over the last six months. DNA rates appeared to have been higher prior to the covid-19 pandemic, with a reported DNA rate of 20% for the general ‘mental health’ clinic between October 2019 and March 2020.

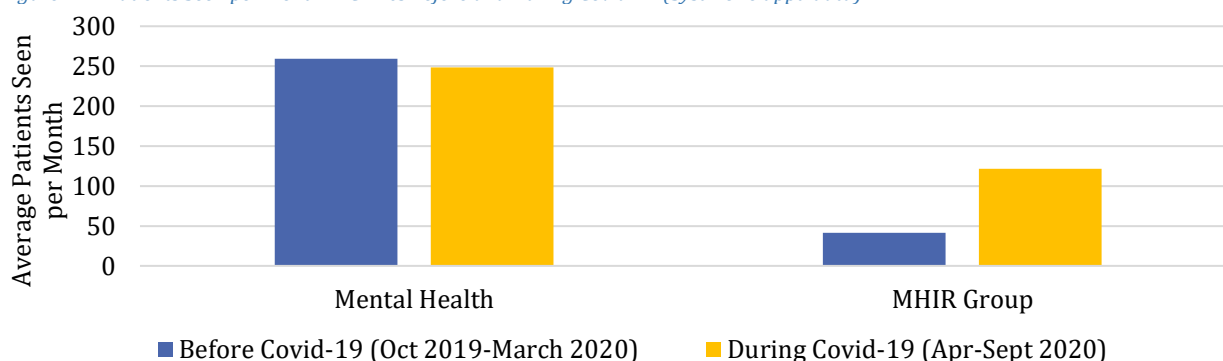
Figure 49 – Mental Health DNA Rates (SystemOne)

Apr-Sept 2020	Average Clinic Sessions per Month	Average Appointments Booked per Clinic Session	Average Seen per Clinic Session	% DNA	% 'No Access'	Clinic Occupancy
Mental health	39.8	6.5	6.2	2%	2%	96%
Mental Health (different code)	5.2	1.3	1.3	0%	2%	98%
MH in-reach (MHIR) group	27.8	4.4	4.4	0%	0%	100%

For the general ‘mental health’ clinic, the average number of patients seen per month in the last six months was quite similar to that in a six-month period (September 2019 to February

2020) before the covid-19 pandemic. As can be seen in the chart below, reported activity for the mental health in-reach group has actually increased.

Figure 50 – Patients Seen per Month in Clinics Before and During Covid-19 (SystemOne appt. data)



There is an unresolved issue of how to support people with mental health problems in the care and separation unit (CSU), where there is no suitable private space to interview anyone. Note that the prison’s view is that anyone in the CSU on an ACCT (assessment, care in custody, and teamwork) should definitely be seen by mental health. Primary care has a similar problem with the lack of a treatment room in the CSU, although appears to largely manage this. It should be possible for the CSU staff and mental health to work out a safe enough option between them, although it may not be ideal from a therapeutic or confidential point of view.

5.3 Findings from Resident Consultation

In our patient survey, 73% of respondents said they knew how to access mental health services. This is average amongst recently surveyed comparator prisons – 71% of patients at HMP Rochester, 78% at HMP Buckley Hall, 65% at HMP Onley, and 81% at HMP Lancaster Farms reported knowing how to access mental health services. Specific patient feedback was a mixture of compliments for support and access during covid-19, and complaints about not enough of the same.

5.4 Proportions of Residents with Mental Health Issues

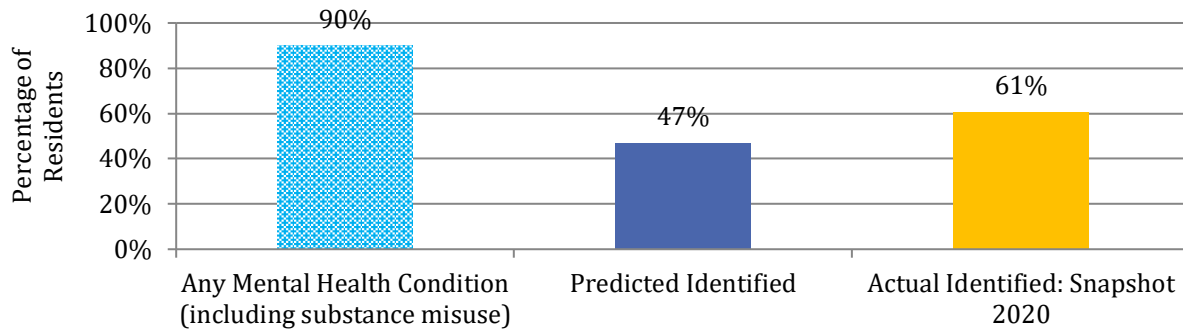
Prevalence estimates from research show 90% of prisoners have some mental health problem (including substance misuse).³³ It should be noted that although this study is almost two decades old, it remains the most relevant prevalence study, conducted in all the (then) 131 prisons, and involving in-depth clinical interviews with a large sample of prisoners.

Based on the above, and the assumption that 52% of those with a mental health condition are likely to be identified,³⁴ it can broadly be estimated that we might expect 47% of the population in HMP Coldingley to be identified with one or more mental health conditions, including substance misuse. This is compared to the actual rates of identification below, with the SystemOne snapshot at October 2020 describing a higher than predicted rate. Comparable data was not available from the last HSCNA. This suggests that the healthcare system at the prison is good at identifying need.

³³ Singleton, N. *et al.* (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. (accessed December 2020).

³⁴ Sainsbury Centre for Mental Health (2003) *Primary solutions: an independent policy review on the development of primary care mental health services*. From a table prepared by Muijen, M. after Goldberg, D. and Huxley, P. (1992) *Common Mental Disorders: A Bio-Social Model*. London: Routledge.

Figure 51 – Expected and Actual Mental Health Prevalence (including substance misuse)

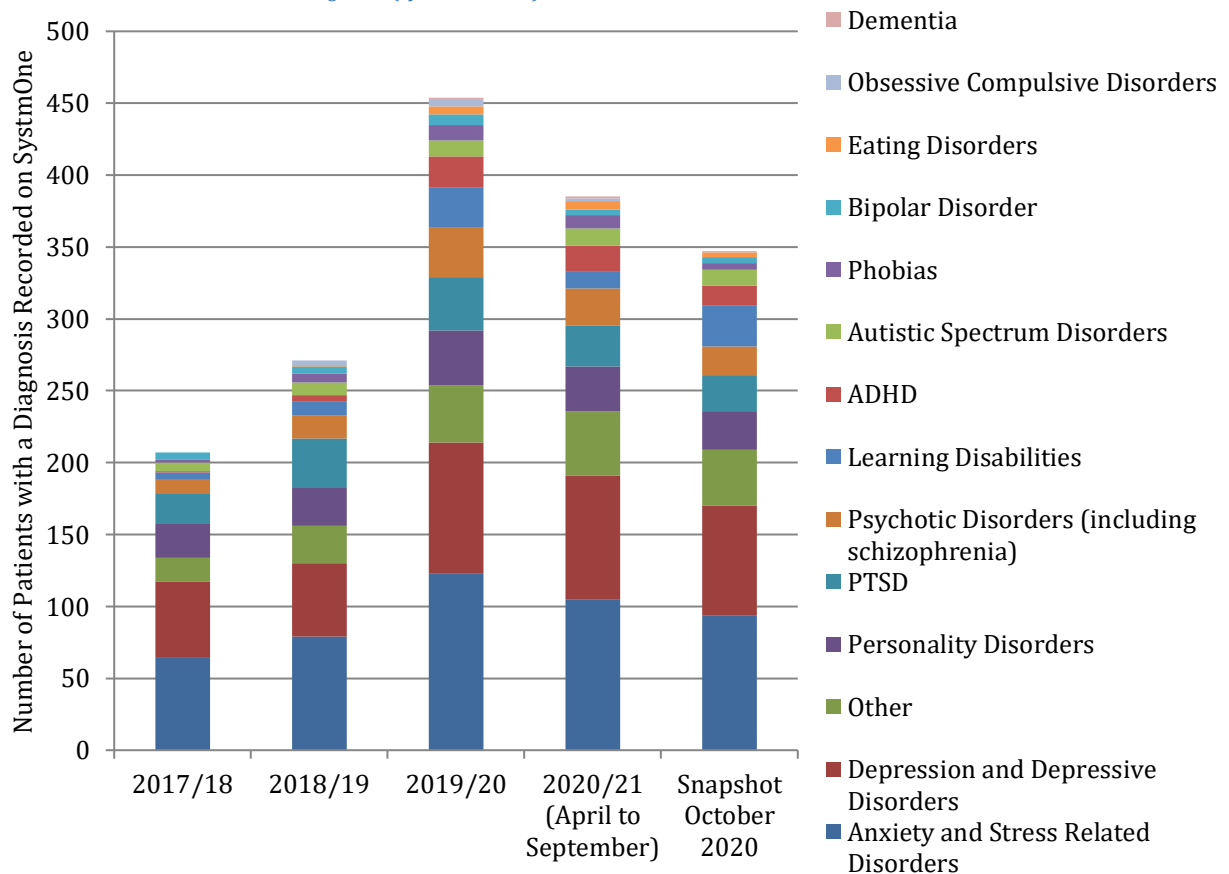


While 271 patients at the October 2020 snapshot were identified as having mental health issues *including* substance misuse, 212 of these were identified with *mental health issues specifically* (including those with dual diagnosis, but not those with substance misuse diagnoses only). SystemOne indicates that of these 212 men (47% of residents) at the snapshot recorded as having a mental health issue, less than half (n=81) had one or more of their conditions recorded at HMP Coldingley. The SystemOne mental health records for the remaining 131 men had been made at other establishments.

While above predicted rates, the overall identification of mental health issues (both including and excluding substance misuse diagnoses) at HMP Coldingley was similar to comparators. This is discussed in more detail later in the chapter.

The chart below shows the number of patients recorded on SystemOne as being diagnosed with various mental health conditions (not including substance misuse), during recent years and at a current snapshot. Note that one patient may be diagnosed with multiple conditions.

Figure 52 – Recorded Mental Health Diagnoses (SystemOne data)



This indicates that the numbers of patients with recorded diagnoses have increased in recent years, with depression and anxiety being the most commonly diagnosed conditions. Note that 2020/21 represents an incomplete year and reduced numbers.

Using prevalence estimates for individual conditions amongst male prisoners (from the same research study noted above), we can provide a further breakdown of common mental health conditions below.

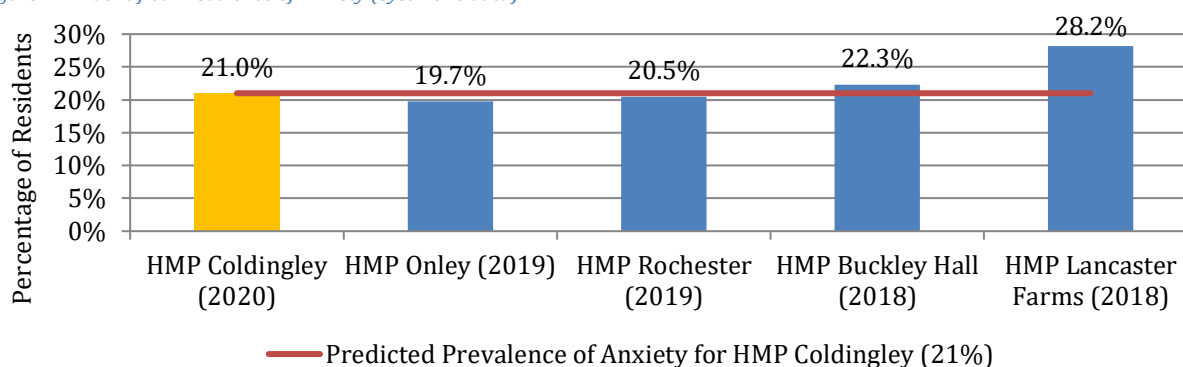
5.4.1 Anxiety and Depression

Anxiety and depression are often termed ‘common mental health issues’ and are normally treated by GPs or IAPT type interventions. Mental health is not commissioned to provide primary mental health services at HMP Coldingley, but what is delivered is largely covered by primary care and mental health together.

The GP – sometimes together with the mental health service lead, who is also an NMP – will ensure any necessary medications. Psychosocial support options are the general ones aimed at the whole prison, e.g. the peer support listeners, and the IAPT groups delivered by the band 4 psychology assistant. There are normally considerable waits for the IAPT provision. Access to listeners and to IAPT groups has largely ceased under covid-19, although some IAPT provision has been delivered on a 1-1 basis and some in-cell packs cover similar ground.

The number of residents identified with anxiety and stress-related disorders is at the 21% expected (n=94 patients). The rate of identified anxiety is also similar to comparator prisons for which this data was available. This suggests that anxiety needs are usually identified, although as said, there are waits for the psychosocial aspects of these needs to be addressed.

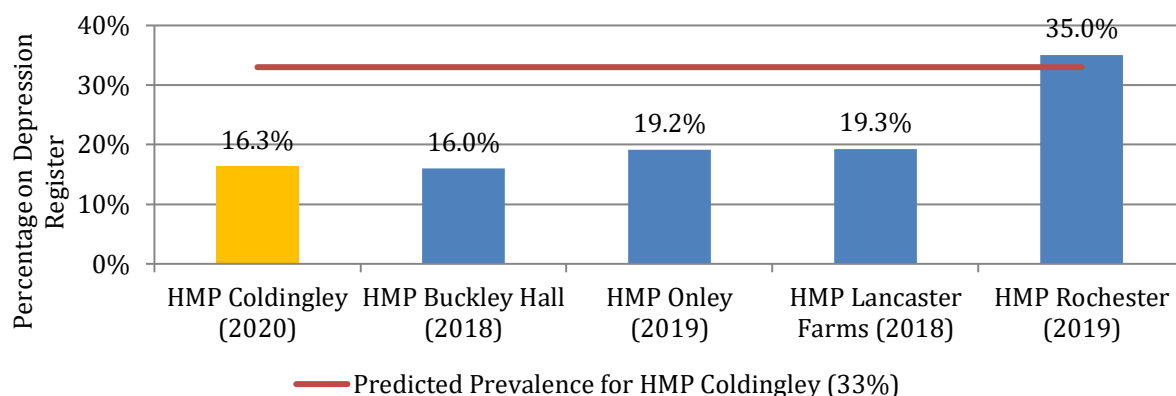
Figure 53 – Identified Prevalence of Anxiety (SystemOne data)



The number of patients recorded on SystemOne with diagnoses of depression (equivalent to 17% of the population of HMP Coldingley) is some way below the predicted 33%. It is also lower than the average of 24% across the four available comparators.

At October 2020 (during covid-19), QOF data showed 16.3% of the population as being on the register for depression (n=73), which, as can be seen in the chart below, is low next to comparator prisons (though most comparators are also well below the predicted prevalence). Some patients may have a recorded diagnosis on SystemOne but not be on the QOF register as currently receiving treatment.

Figure 54 – Depression Prevalence (QOF Register data)



It may be that the typical identified prevalence of depression at HMP Coldingley is higher than at our snapshot. Between October 2019 and March 2020 (a pre-pandemic period taken as more likely to be indicative of ‘normal’ activity and identification), an average of 17.8% of the population were on the QOF depression register.³⁵ This is, however, also well below predictions and lower than most comparators.

Mental health felt that the introduction of the early days screen had increased identification of mental health issues. It was not clear why anxiety appeared to be recognised and treated, whilst this was not the case for depression. We suggest this possible gap in identifying and meeting need is explored by mental health, ideally together with residents, and pathways revised as necessary.

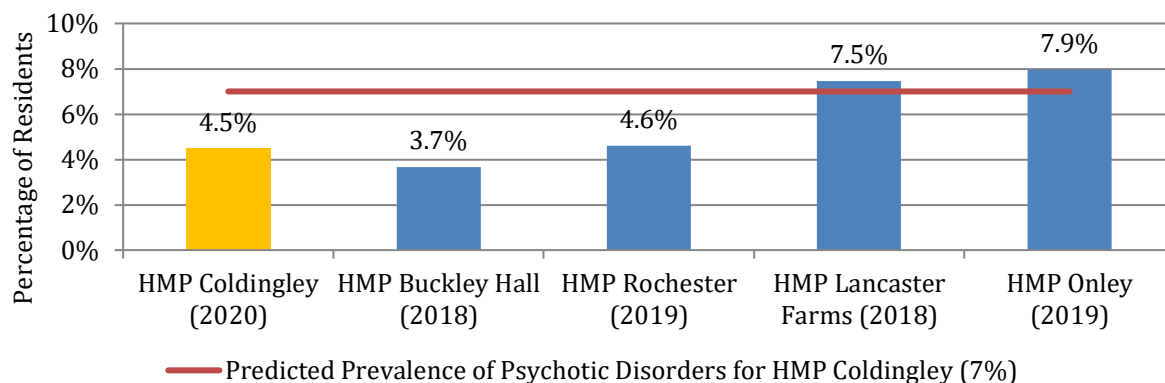
Recommendation 16: Mental health and patients to explore depression pathways and provision, to inform improved identification and response to depression.

5.4.2 Psychotic Disorders

The identified rate of psychotic disorders (including schizophrenia) is lower than the 7% predicted, and also lower than most comparators. Mental health felt that this was probably because HMP Coldingley is a working prison so the potential sending establishments would tend not to send people who might not be consistently fit for work. Mental health reported that secondary mental health cases tended to be more stable than might be expected, which supports that theory. Numbers were consistently fairly low. Our conclusion is that the need is probably being met.

³⁵ Based on 'How Am I Driving' QOF data for the period October 2019 to March 2020; population during this period is taken as the average of the MOJ-reported population (from [Prison Population Figures](#)) over the same six months. (checked December 2020).

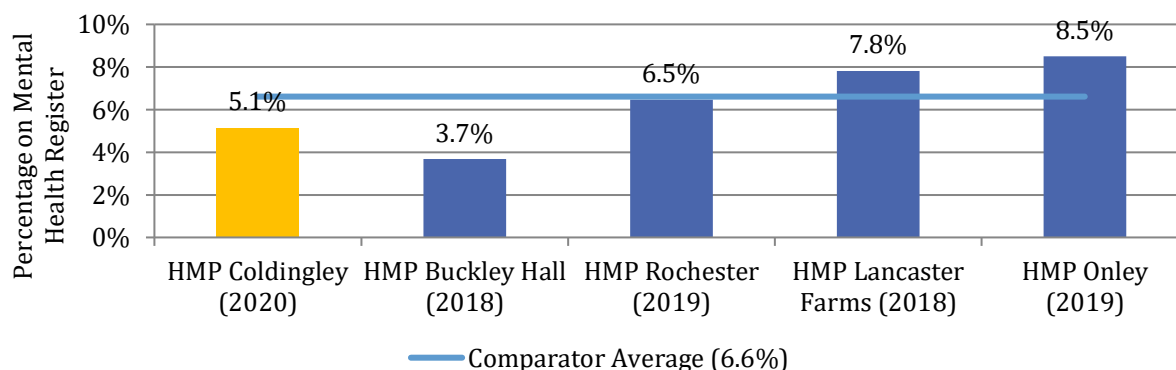
Figure 55 – Identified Prevalence of Psychotic Disorders (SystemOne data)



5.4.3 Severe and Enduring Mental Health Issues

Quality and Outcomes Framework (QOF) data showed that 5.1% of the population were identified as having severe and enduring mental health problems (including schizophrenia, bipolar affective disorder or other psychoses) at our October 2020 snapshot. This is a little below average next to comparators. The average identified prevalence during an earlier six-month period (October 2019 to March 2020) was 6.9%, which is more closely aligned with comparators.

Figure 56 – Severe and Enduring Mental Health Prevalence (QOF register data)



As discussed above, the more complex or unstable secondary mental health problems are less likely to be sent to HMP Coldingley, so we feel that it is likely that the needs of those with severe and enduring mental illness are likely being met. Mental health reports that where someone’s condition worsens during their stay, this does not necessarily mean that they are automatically transferred, each case is considered individually by the prison and mental health team. This is the target group that the mental health service at HMP Coldingley was largely set up for initially, and we feel that the need is probably being met.

5.4.4 Dementia

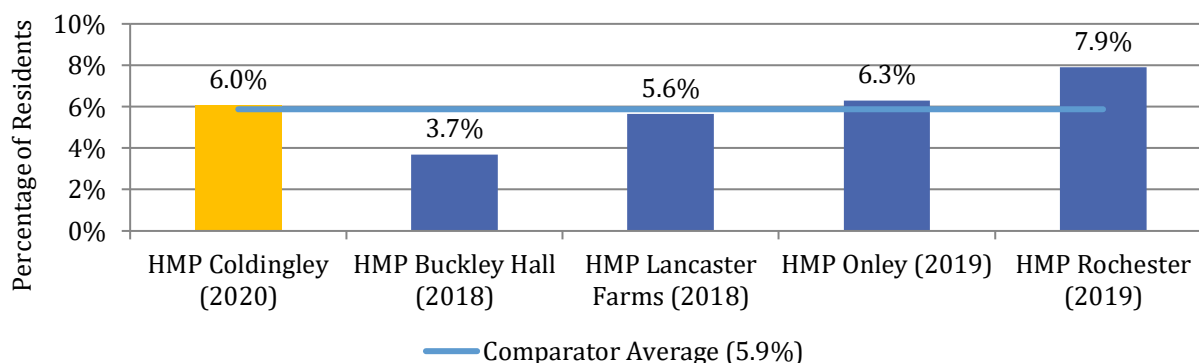
SystemOne reported fewer than five current diagnosed cases of dementia at an October 2020 snapshot, all of which were on the QOF register. This is something of an outlier as staff report that normally dementia would be exclusion criteria, i.e. this would only occur if the condition had developed whilst the person was at HMP Coldingley. Note that none of the comparator prisons had any cases. The normal pathways would be joint work between the psychiatrist and the GP, with input from local specialist secondary services as needed. If the care needs

became such that out-of-hours care was required, the person would be transferred to somewhere with such care. This would be almost certainly mean a return to closed conditions and possibly an inpatient unit, and would be considered a regressive step by most patients. As far as HMP Coldingley goes, need appears to be being identified and met.

5.4.5 Personality Disorder

Whilst the apparent identification of those with personality disorders (PD) is well under predictions (with a predicted prevalence of around 64% among sentenced male prisoners, as described in Part B), it should be noted that the predictions include a wide range of personality disorders (including antisocial personality disorder which could include criminal behaviour) and varying levels of complexity, need and risk. Those identified in HMP Coldingley (6%) on the other hand, will have a formal diagnosis. To put this in context, identification at HMP Coldingley was average among comparators.

Figure 57 – Identified Prevalence of Personality Disorder (SystemOne data)



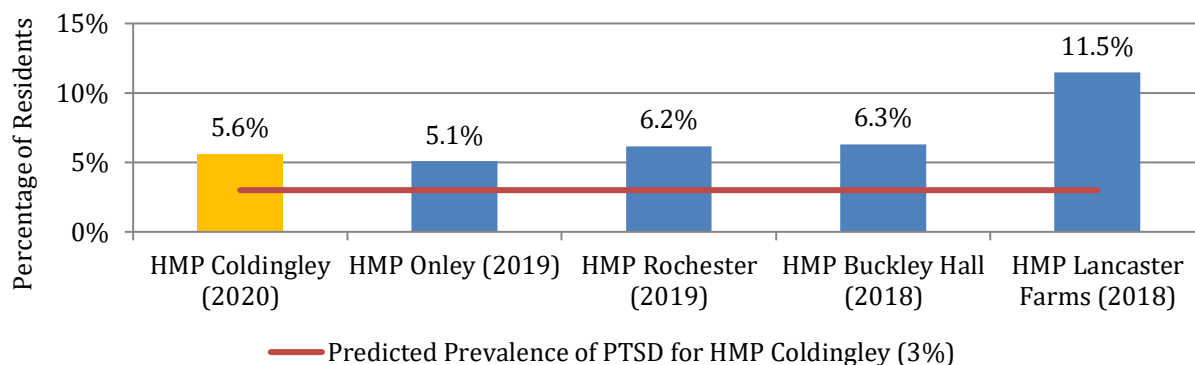
The prison reported that it used to be the practice to refuse the more severe personality disorders or to transfer them onwards, but that this was less the case now, and as such the need had risen. Mental health reported that personality disorders were common, but that they tended to be stable and less severe or complex. The more severe of those at HMP Coldingley were jointly managed by mental health and psychology, but there was a very limited resource for the kind of longer-term interventions needed and large waiting lists. Some residents with personality disorders had these noted in their sentence plans, but it was difficult for these to be addressed as required. The prison could access some forensic psychology, but again, longer-term interventions were in short supply. Whilst the personality disorder needs at HMP Coldingley are usually not severe and hence potentially not a priority, much of the need is clearly not being met.

Recommendation 17: Review personality disorder pathways and resources so more of the need can be addressed.

5.4.6 Post-Traumatic Stress Disorder (PTSD)

The identified rate of PTSD is higher than predicted, at 5.6% (n=25) compared to 3% predicted. However, as can be seen from the chart below, all comparators were also above the predicted rate of identification, with HMP Coldingley having a lower rate than most comparator prisons.

Figure 58 – Identified Prevalence of Post-Traumatic Stress Disorder (SystemOne data)



Mental health felt that most of the PTSD codes were probably not formal diagnoses but rather an acknowledgement of trauma-related problems. These were usually identified in the psychology screen, and where needs were identified these would usually be met by psychology. These could be lower-level interventions such as CBT and eye movement desensitisation and reprocessing (EMDR) (both available), but could also be longer-term psychological and psychotherapeutic interventions. Many of the psychological interventions can involve long waits as the existing resource is insufficient to meet need, particularly for long-term therapy. It is apparent that much of the need for trauma-focused interventions is not being met.

Recommendation 18: Further resources to be developed to support trauma-focused interventions.

One point noted by several of the people we interviewed is that the prison is next to a military firing range and that this triggers PTSD in some of the population, particularly the military veterans (see [section 2.3.8](#)) and some gang members. We recommend that extra consideration is given to what kinds of prisoners with PTSD are sent to HMP Coldingley. This risk can be reduced by communicating with the offender management units and mental health/psychology teams in the main sending prisons and, where possible, by examining any accessible records.

Recommendation 19: Consider which cases of PTSD can be placed at HMP Coldingley.

5.5 Mental Health Transfers

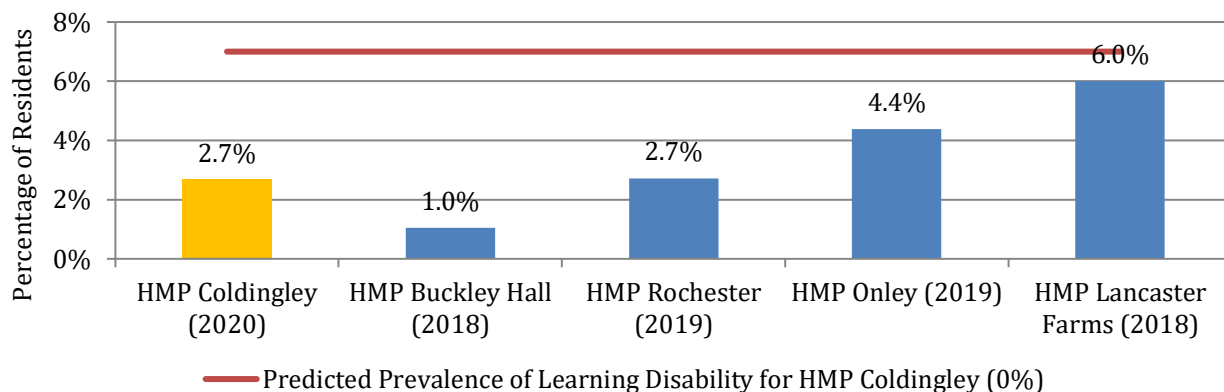
Healthcare reported no patients referred for transfer under the Mental Health Act (MHA) in the twelve months to October 2020. This is atypical among comparators, which reported between 0.4 and one transfer per 100 residents per year, and is probably because the type of residents who might require a MHA transfer would not likely be sent to HMP Coldingley in the first place.

5.6 Learning Disabilities/Intellectual and Development Disability

The recorded prevalence of learning disability (LD) in HMP Coldingley is below the predicted 7%. This is not unusual among comparator establishments, although identification at HMP Coldingley is also lower than at most comparators. QOF data for October 2019 to March 2020 described a similar proportion of the population being identified (2.1%). As with other

conditions, it is likely that the LD diagnosis would sometimes act to exclude possible transfers into a working prison.

Figure 59 – Learning Disability Prevalence (QOF register data)



The above describes the percentage on QOF, so should indicate those who are being actively managed. SystemOne data showed a slightly higher number and proportion of patients (6.3%, or 28 patients, compared to 12 patients on the QOF register) with any recorded diagnosis. The performance lead for the Surrey prisons felt that LD was often over-recorded due to the continuation of historical records and the absence of a formal assessment and diagnosis. Mental health reported that the LD nurse was working with eight patients.

In our patient survey, 10% of respondents (n=5) reported that they had a learning difficulty or disability. This is low next to most comparators for which this data was available (9% at HMP Buckley Hall, 17% at HMP Rochester, 12% at HMP Onley, and 18% at HMP Lancaster Farms).

CNWL employs a full-time band 7 learning disability nurse across the four public sector prisons in Surrey. In practice, he also covers autism, discussed further in the next section. He spends a day at week in HMP Coldingley. There is no specialist cover, rather mental health will cover any pressing needs. The LD nurse believes the cover arrangements are adequate. Since covid-19, he has largely worked remotely although has recently recommenced working on-site. Note that there are no in-cell phones at HMP Coldingley, though there are telemedicine facilities. Both would help support a wide range of healthcare provision.

The normal pathway for a recognised learning disability is that it would be picked up in the primary care screening, referred to mental health triage, and then referred to the LD nurse if LD is indicated. Referrals come from a range of other sources including OMU, officers, education, and outside professionals.

The LD nurse uses the same definition as in the community to differentiate between learning disability and learning difficulty, i.e. a learning disability involves a significantly reduced ability to understand complex information or learn new skills (impaired intelligence), a reduced ability to cope independently (impaired social functioning) and is a condition which started before adulthood (18 years of age) and has a lasting effect.³⁶ Where the LD screen indicates a difficulty as opposed to a disability then the nurse will signpost and refer if indicated. Note that education treats this as more of a continuum and will develop appropriate education plans as required for that individual's needs.

³⁶ DH (2001) [Valuing People: A New Strategy for Learning Disability for the 21st Century](#) (accessed December 2020).

The LD nurse is not qualified to make a formal diagnosis, and this lack of a diagnosis can be a problem when trying to establish throughcare, i.e. some community agencies will not accept a referral without a confirmed formal diagnosis. The nurse reports that if the diagnosis is not an issue, then it is often possible to access services in the community for after the person's release. Release planning starts as early as possible, although still does not always go smoothly.

If a learning disability is established (formally or through the screen), then the LD nurse will develop a care plan identifying and addressing that person's needs. The LD nurse works closely with [social care](#), and the care plan may involve a referral to social care. This is often for support with day-to-day living, e.g. keeping the cell tidy, understanding the regime, and so on.

The LD nurse and primary care have been trying to ensure the annual health checks for people with learning disabilities, but this has been hampered by covid-19.

The LD nurse has built up a library of easy read information, including regarding covid-19, and this is available to residents and other staff. The nurse also attends and gives evidence for parole hearings, etc.

The LD nurse felt that there could be sufficient resource to meet the need for direct support and interventions for learning disability if that was the only part of the remit, however, they have also become a specialist resource for autism and cannot easily cover both areas. In addition, there is a largely unmet need for training and education for staff and peer workers around learning disability/difficulty and autism. In terms of LD need being met, it is likely that most of the need is being identified and largely met, although the pathways need further development – e.g. to include the potential for formal diagnoses – and training/education is limited. The discussion in the next section on autism is also relevant in this respect.

Recommendation 20: Develop the LD pathways and support for other staff.

Education recognised how learning difficulties and mental health issues could make education difficult for learners and how, in turn, education could be of help for people with learning difficulties or mental health problems. The latter has been a challenge with regard to covid-19 as most of the residents – particularly those with lower levels of ability – have been receiving little or no education during lockdown.

Education felt competent at working with learning difficulties and to some extent autism, though the commissioning and contractual structure involved was complex. Of interest is that education has noticed how covid-19 has highlighted some of the hidden literacy issues as the isolation involved means residents have been less able to use others to cover their own literacy problems. This was particularly the case in residents from the traveller community.

Education was less confident where mental health issues were involved and if the resources were available there would be potential in more partnership working between education and mental health.

5.7 Autistic Spectrum Disorders (ASD)

The identified prevalence of autistic spectrum disorders at HMP Coldingley is a little higher than that predicted by the research, with 11 identified patients (or 2.5%) recorded on

SystemOne, against an expected prevalence of 1.5% for men in England.³⁷ The rate is fairly similar to comparators, with an average of 2.0% identified across four comparator establishments. This higher than expected prevalence may be at least partly be that the LD nurse also covers autism and has helped to raise the profile of the issue, as well as providing a service to which people can refer.

The LD nurse's role is described in more detail in the preceding section. The pathways for autism are broadly similar to those for LD, although it is much more likely that there will not be an existing diagnosis – formal or otherwise – and therefore referrals are less likely to come at the point of reception, but are more often later, and in many cases autism may never have previously been considered as a potential issue. The mental health service lead felt that there was a greater need with respect to autism than there was for learning disabilities.

The LD nurse will carry out an autism screen. Formal diagnoses have previously been sought from a psychiatrist, although this is currently in abeyance due to covid-19 and there is a large waiting list for these specialist assessments. It is not clear who is responsible for paying for such diagnoses. Beyond the point of screening, the LD nurse can help develop a care plan if needed and offer some limited support.

CNWL is currently in the process of reviewing autism pathways for offenders in recognition of a large increase in need, drawing on experience and good practice from HMYOI Feltham. Possible elements are a multidisciplinary approach involving nursing, speech and language therapy, and occupational therapy. Any such development would almost certainly be an area resource and would hopefully also be involved in the training and education of staff and peer workers.

Whilst some of the autism need is being identified and met, it is likely that a lot is not being identified and may not be, without increased staff awareness and extra specialist resources. Need that is identified is partially met, but could be better met with an increased range of specialist staff (e.g. speech and language) to address specific needs.

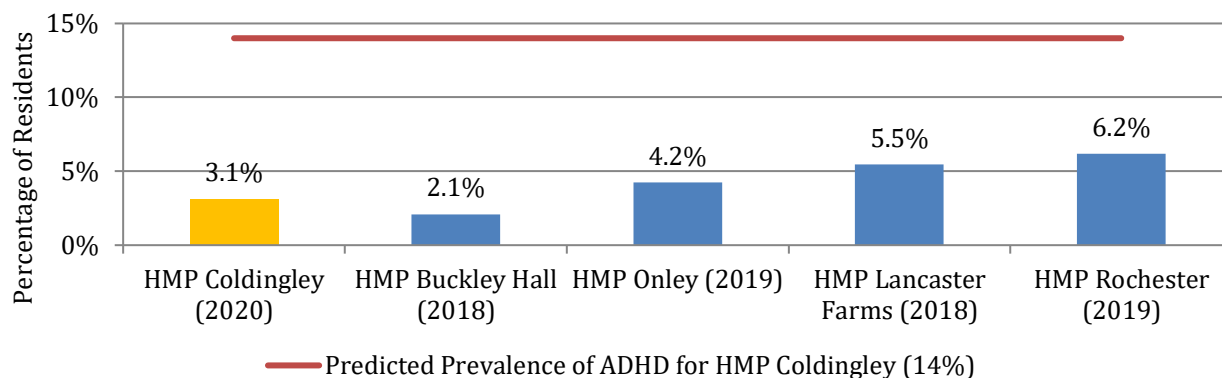
Recommendation 21: Further develop multidisciplinary autism pathways and resource.

5.8 Attention Deficit Hyperactivity Disorder (ADHD)

At 3.1% (n=14), the diagnosis rate for ADHD is lower than the average among comparators and below the projected 14% among a male prisoner population. This is surprising considering the well-developed ADHD pathways at HMP Coldingley, though may be a product of a reluctance by some sending prisons to transfer some of their ADHD patients to HMP Coldingley if they feel they may not be suitable for a working prison.

³⁷ NHS (2014) [Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014](#).

Figure 60 – Identified Prevalence of ADHD (SystemOne data)



SystemOne prescribing data in October 2020 indicated seven patients with a current record of a prescription for ADHD medication (mostly lisdexamfetamine, some atomoxetine) and at least 17 during 2019/20.

As ADHD is now considered a secondary mental health issue, it comes under the remit of the mental health team at HMP Coldingley. This has implications for release into the community as, technically, the patient will fall under the care programme approach, although it is probable that not many community mental health services have well developed ADHD pathways for adults.

HMP Coldingley has good pathways for ADHD and is more likely to prescribe (and in a more considered way) than many other prisons. It tends to prescribe lisdexamfetamine rather than methylphenidate because of the former’s shorter half-life, meaning it fits better with the working day and is less disruptive to sleep (note that it is a misusable stimulant). Where methylphenidate is used, then this is with consideration of consistency in brand usage, e.g. sticking to concerta, as the NMP believes this may have a clinical impact. The ADHD pathway tends towards using melatonin if help is needed with sleep.

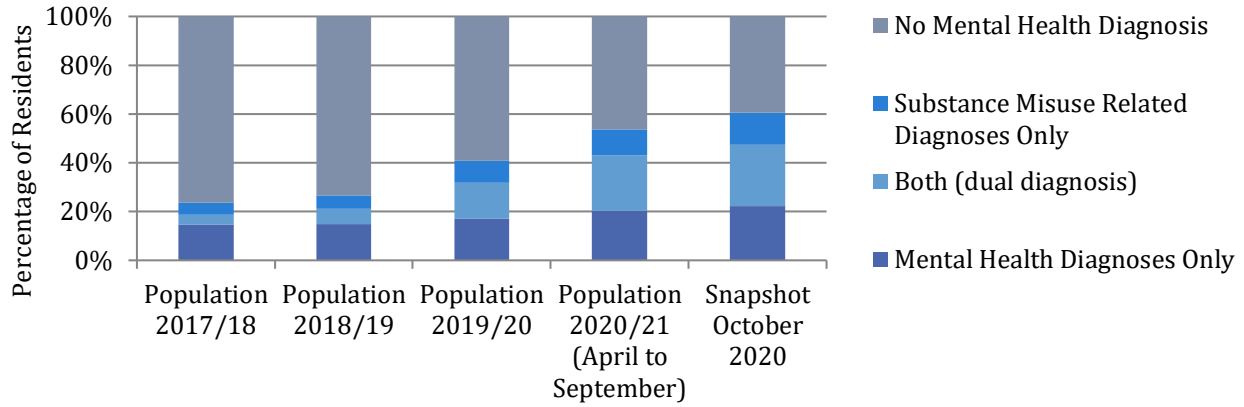
The mental health lead notes that there was a lot of variety in how ADHD was managed within the prison estate, and a need for some consistency nationally, perhaps from NICE. There is such guidance for the community, just not specific to the secure estate.

Although the numbers identified and treated are low, the well-developed screening, diagnosis and treatment pathways suggest that ADHD need is being identified and met at HMP Coldingley.

5.9 Mental Health and Dual Diagnosis

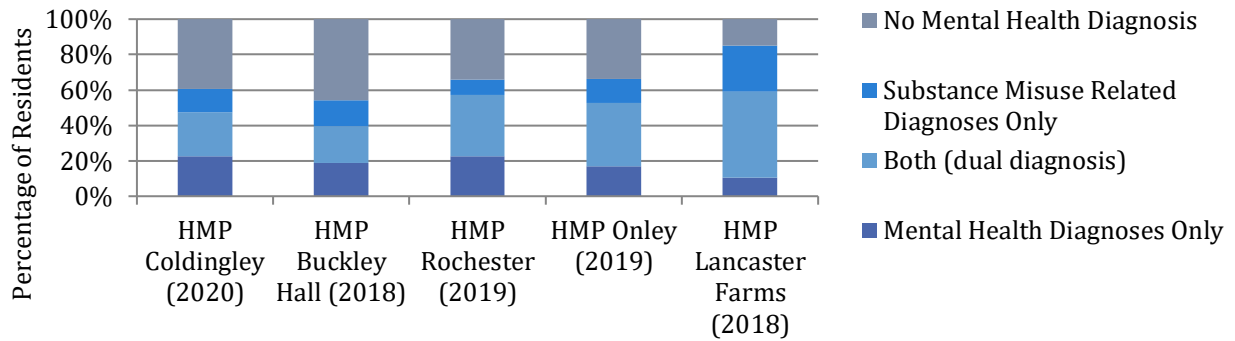
The chart below shows the proportion of the population recorded on SystemOne as having mental health and/or substance misuse problems over the past few years. This shows a steady increase in recorded mental health problems (a similar picture applied to diagnosis rates among new receptions nationally, indicating improved identification and recording across the prison estate). In HMP Coldingley, there is a marked increase in recorded mental health problems and in substance misuse diagnoses, with the greatest rise being in patients with both (dual diagnosis).

Figure 61 – Mental Health Prevalence Over Time (SystemOne data)



However, as can be seen in the chart below, the overall identification of mental health disorders at HMP Coldingley is a little below average among comparators for which this data is available, perhaps for the reasons already discussed regarding some potential placements being excluded as unsuitable for a working prison.

Figure 62 – Mental Health Diagnosis Comparison (SystemOne data)



The mental health lead reported that dual diagnosis worked well and that there were monthly meetings (primary care said fortnightly) between the two services. What does not work so well is access to information, specifically records. Forward Trust is reported as happy to share information but has its own record-keeping system, and the whole process would be smoother and simpler if there were common accessible records on SystemOne. This would also better support co-ordinated risk management and care. Dual record-keeping is a wasteful solution, it would be better if the substance misuse services used SystemOne as a matter of course.

Recommendation 22: Forward Trust to ensure full records on SystemOne.

5.10 Chapter Summary

- Mental health provision is good but limited by resource. The model needs review and appropriate resourcing if needs are to be met (see **Recommendation 11**).
- Psychology is a separate team from mental health (see **Recommendation 12**).
- There is a lack of mental health nurses (see **Recommendation 13**).
- Psychiatric staffing is adequate, though there is a range of unmet psychology need (see **Recommendation 14**).
- Resources for primary psychosocial and longer-term interventions are inadequate (see **Recommendation 15**).
- Anxiety is being identified, though some depression may be being missed (see **Recommendation 16**).
- The needs of those with severe and enduring mental illness are met.
- There have been no recent Mental Health Act transfers.
- The needs of those with personality disorder are not being met (see **Recommendation 17**).
- There are insufficient resources to address the longer-term impacts of trauma (see **Recommendation 18**).
- The neighbouring firing range has an adverse impact on some residents (see **Recommendation 19**).
- LD pathways are good, but there is insufficient resource to fully meet the direct need and a need for training for staff (see **Recommendation 20**).
- Autism pathways need developing and there is insufficient resource to fully meet the direct need and a need for training for staff (see **Recommendation 21**).
- ADHD pathways are good.
- Dual diagnosis pathways are good, though would be improved with common record-keeping (see **Recommendation 22**).

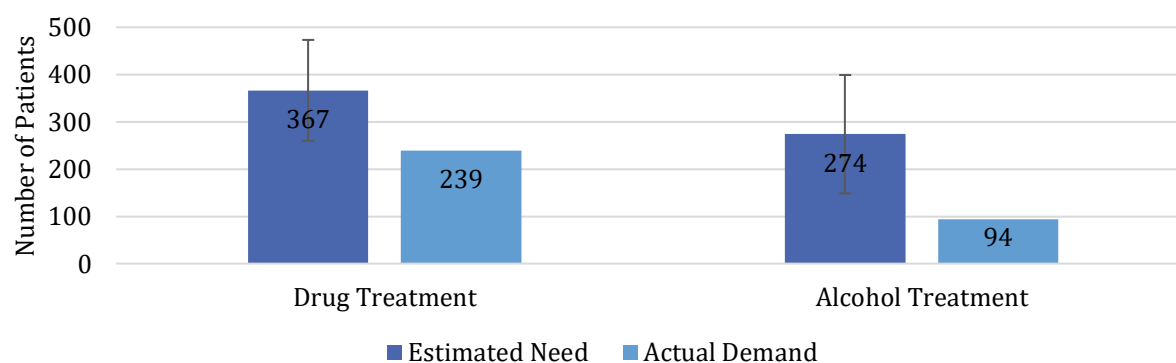
Chapter Six – Substance Misuse

Data relating to substance misuse is derived mainly from the national drug treatment monitoring system (NDTMS). Full NDTMS data is included in [Appendix D](#). The provider reported that although clinical activity and some relevant psychosocial activity was recorded on SystmOne, this was not the main recording system and as such SystmOne records were not necessarily complete and accurate (see [Recommendation 22](#)).

6.1 Prevalence

The following charts compare the expected annual incidence of substance misuse among the population of HMP Coldingley to the actual demand for treatment, based on NDTMS data (on the full year 2019/20 as reported to NDTMS). Calculations for the expected incidence are based on an average male prison population, and can be found in [Appendix C](#).

Figure 63 – Predicted Incidence and Actual Demand (per annum)

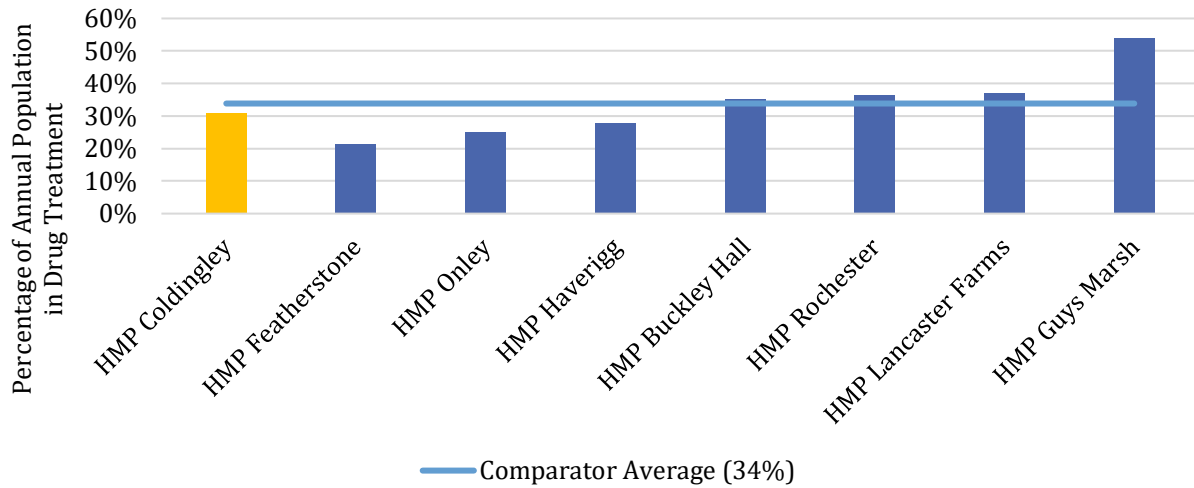


The observed demand for drug treatment at HMP Coldingley is lower than predicted but close to the bottom end of the likely range. This is likely to be a product of the population of a working prison, i.e. less likely to have had a history of substance misuse and perhaps less likely to declare it. This is also reflected in the types of drug use reported. The substance misuse service report that whilst this picture of less serious substance misuse histories is broadly the case, recently (including prior to covid-19) there has been a trend towards receiving men earlier in their sentence and on shorter sentences, and with this has come an increase in the numbers who have used illicit drugs and an increase in the seriousness of their drug use, including greater numbers on opioid substitution therapy (OST).

NDTMS data indicates that only 33% of those recorded as being in treatment in 2019/20 were opiate and crack users (OCUs); 59% were primary users of non-opiate substances, (29% with and 30% without alcohol), and 7% were primary alcohol users. This substance use profile is more skewed towards non-opiate use, and includes a lower proportion of opiate users, compared to that in training prisons on average.

As a useful comparison with similar prisons, the number of patients recorded on NDTMS as entering drug treatment in 2019/20 in relation to the annual population of the prison (op cap plus receptions to the prison as reported on NDTMS) is slightly below average at HMP Coldingley.

Figure 64 – Ratio of Drug Treatment Patients to Op Cap (NDTMS data, 2019/20)

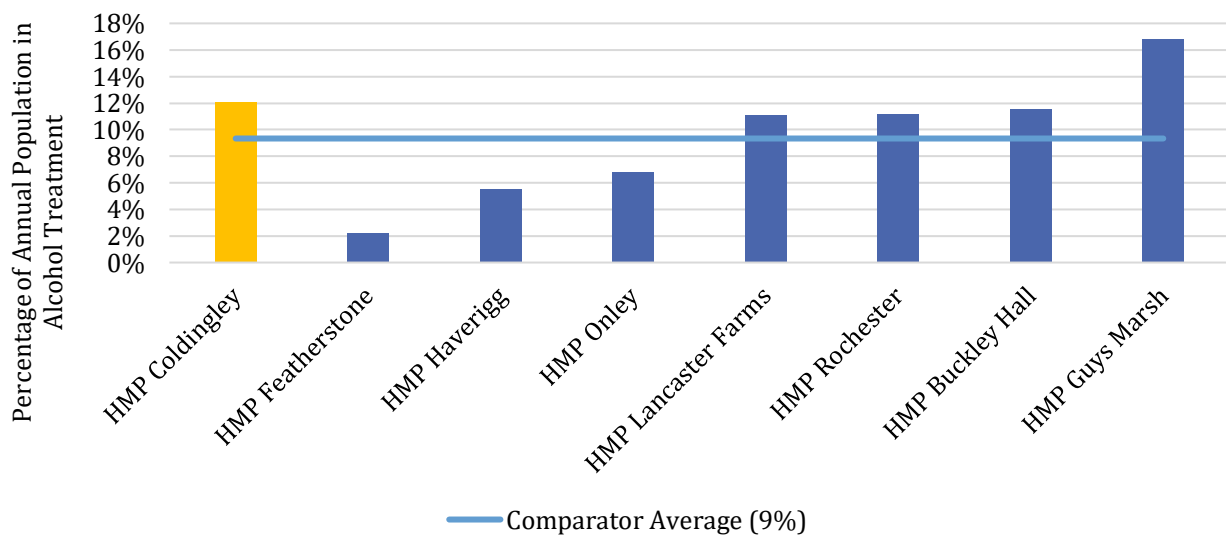


For alcohol treatment, the observed demand at HMP Coldingley is much lower than predicted. It is, however, important to note that the figure for actual treatment demand above will not include those reporting alcohol use alongside opiate drugs. All those reporting opiate use are categorised on NDTMS as opiate users, regardless of other substance use.

In addition, as all men received into HMP Coldingley have come from other prisons, those with acute clinical treatment needs relating to problematic alcohol use should have received (and completed) treatment in their reception establishment.

During 2019/20, 59 patients were recorded on NDTMS as having an AUDIT (alcohol use disorders identification test) score of 20 or above, indicative of probable dependent drinking (AUDIT is part of the specialist assessment). This was a smaller proportion of patients (23%) compared to substance misuse patients in prisons nationally (31%) and reinforces the hypothesis that the HMP Coldingley population is generally situated along the less problematic part of the continuum of substance misuse compared to other training prisons.

Figure 65 – Ratio of Alcohol Treatment Patients to Op Cap (NDTMS data, 2019/20)

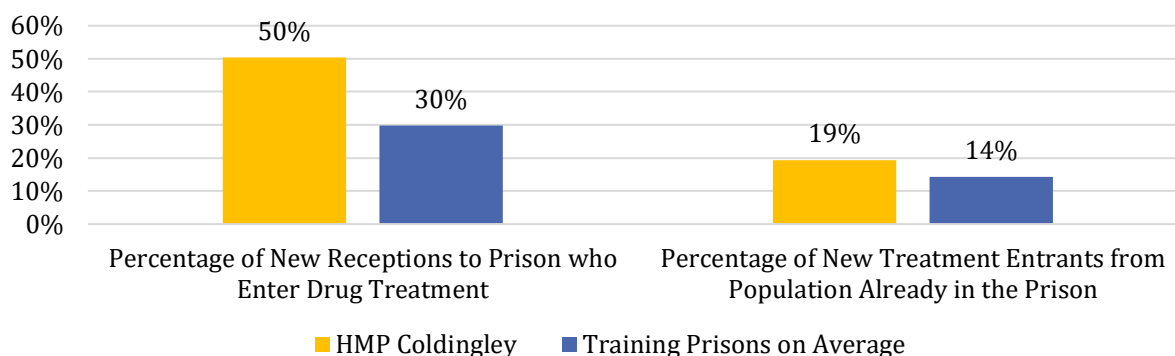


The chart above shows engagement with alcohol treatment in comparator prisons as a percentage of each prison’s annual population (op cap plus receptions as reported to NDTMS). The rate of engagement with alcohol treatment in HMP Coldingley is above average relative to

comparator prisons, suggesting HMP Coldingley is particularly good at engaging drinkers in treatment.

NDTMS data suggests that compared to the average for training prisons, a considerably higher proportion of new receptions to HMP Coldingley enter drug or alcohol treatment. In addition, a slightly higher proportion of treatment entrants came from the existing prison population (i.e. did not enter treatment directly from reception). This reinforces the view that although below predictions in overall numbers potentially needing treatment, HMP Coldingley is above average compared to other training prisons in terms of engaging people into treatment.

Figure 66 – Treatment Entrants Data (NDTMS, 2019/20)



The substance misuse staff felt they were good at identifying and engaging substance misusers. Primary care was good at identifying and referring on, and substance misuse peer supporters saw all new receptions whether they were identified as substance misusers or not. Our conclusion is that most substance misuse needs are likely identified and met.

6.2 Staffing

The substance misuse service in HMP Coldingley is known as the integrated wellbeing and recovery service and is provided by the Forward Trust, which also provides similar services in the other public sector Surrey prisons. The service is available seven days per week, with provision from 8am to 4pm Monday to Friday, and 8-10am at weekends. Everyone we spoke to seemed happy with these hours.

6.2.1 Clinical

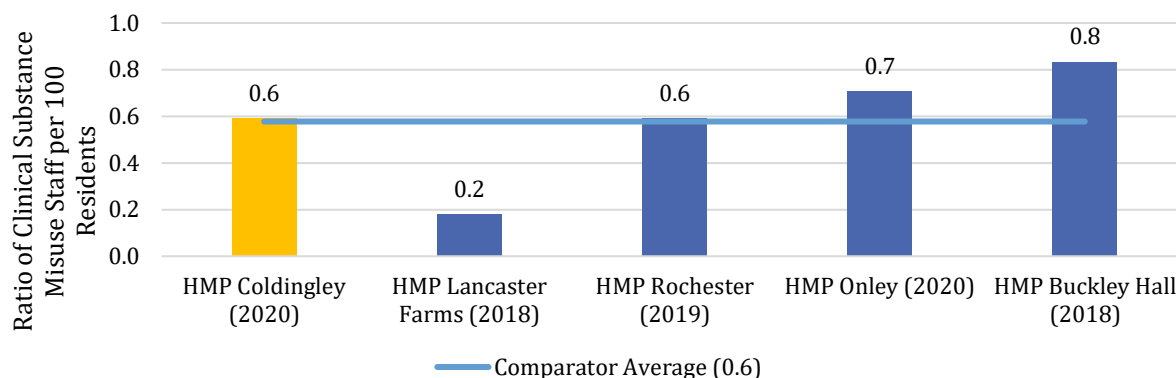
The staffing profile for the clinical element of the substance misuse team is detailed below:

Figure 67 – Clinical Substance Misuse Team Staffing

Role	Band (or equivalent)	Full-time Equivalents	Comments
NMP	7	0.2	Also covers HMPs Send, Downview and High Down.
Senior nurse	6	0.5	Also covers HMP Send.
Substance misuse nurse	6	2	Was one, recent reconfiguration and use of underspend across HMPs Send and Coldingley, allowed an extra nurse.

The chart below illustrates that HMP Coldingley has an average level of clinical substance misuse staffing (in relation to the size of the prison population), compared to other similar prisons for which recent data was available.

Figure 68 – Clinical Substance Misuse Staffing Ratio (based on op cap)



The level of clinical need is low and, outside of administering OST, could be managed by a single nurse. However, OST requires staffing seven days/week involving two people. At HMP Coldingley, the second signatory is nearly always one of the psychosocial substance misuse staff. This increases flexibility, allows a more appropriate skill mix, and means that the psychosocial staff involved are able to offer some level of psychosocial intervention over the weekend as well as during their core working hours in the week.

Primary care reports that it would be rare to assist with the substance misuse administration of OST (or vice versa), although agreements were in place under covid-19 for cross-cover in emergencies. There is also a history of OST cross-cover with HMP Send. Where there are low levels of OST, it is not unusual in some establishments for primary care to cover the weekend administering of OST, and where it is very low, primary care might cover all of it, although this is currently uncommon. Such an approach is often more economical, though with a loss of expertise in the wraparound interactions often involved in administering OST.

At an October 2020 snapshot, the substance misuse service reported 19 patients receiving clinical treatment (of whom all were also receiving non-clinical treatment). Staff report that even pre-covid-19 the number on OST rarely exceeded 24. All of these were continuations of treatment delivered in previous prisons. The team reports that alcohol detoxes are nearly always finished by the time the person comes to HMP Coldingley, so almost all clinical interventions are OST.

All of the prescribing at HMP Coldingley is done by Forward Trust’s NMP who attends the prison weekly for assessments, reviews, etc., and can prescribe remotely if required (this would be a continuation or minor adjustment to existing OST, never a new course of treatment). The team can also contact the regional nurse lead (an NMP) or the substance misuse GP at HMP/YOI High Down if necessary, and in theory at least, can contact the out-of-hours GP.

6.2.2 Psychosocial Staff

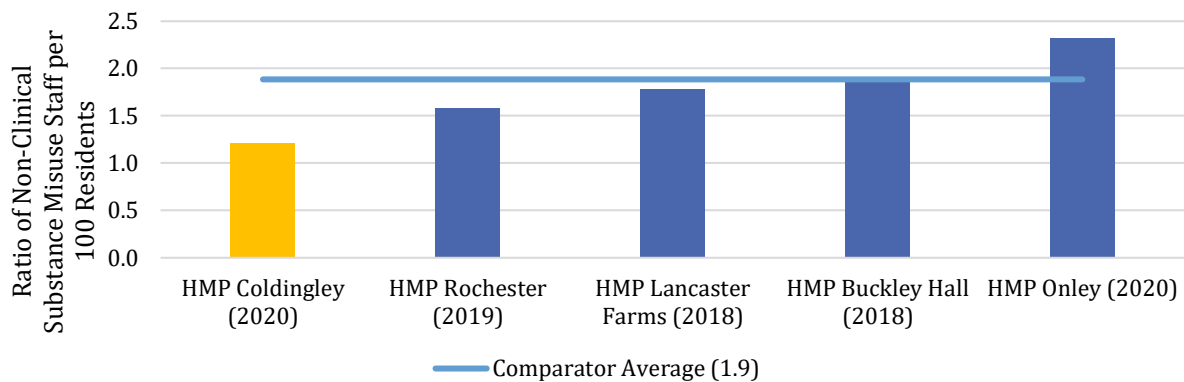
The staffing profile for the non-clinical substance misuse team is detailed below:

Figure 69 – Non-Clinical Substance Misuse Team Staffing

Role	Full-time Equivalents
Service manager	1
Wellbeing and recovery practitioner	4
Family practitioner	0.5
Administrator	0.5

The chart below illustrates that HMP Coldingley has a relatively low ratio of non-clinical substance misuse staffing to the size of the prison population, next to comparator prisons for which recent data was available.

Figure 70 – Non-Clinical Substance Misuse Staffing Ratio (based on op cap)



As the quantity and level of need at HMP Coldingley may be lower than comparators, it is difficult to say for certain whether the staffing is likely to be sufficient to meet need, although we think broadly it is. However, this is unlikely to be sufficient if additional input is required for the proposed new drug-free wing discussed in the next section.

At an October 2020 snapshot, the substance misuse service reported 111 patients receiving non-clinical treatment (of whom 17%, n=19, were also receiving opioid substitution prescribing).

The service is usually supported by five full-time paid peer supporters, but as the peer supporters cannot go on other wings than their own due to the covid-19 transmission risk, they are currently very restricted in what they can do. Recruitment of peer supporters was on hold until covid-19 is no longer a concern, and natural turnover means there is currently only one peer supporter remaining. The service has just started a new round of recruitment in readiness for when the peer supporters can work as normal. The peer supporters provide 1-1 support for other residents, are involved in all groups, help with in-cell packs, and collect referrals, amongst other things.

6.3 Service Provision

Groupwork sessions are listed below:

Figure 71 – Substance Misuse Group Provision (service data)

Group/Programme Name	Number of Participants	Duration (number of sessions)	Is the Programme Accredited?
Stepping Stones	12	20	No
The Bridge Programme	12	30	Yes
Social skills workshops (various topics)	12	1	No
Nacro workshops (various topics)	12	4	No
Family Ties	12	8	No
Auricular acupuncture	12	Unknown	No

The Stepping Stones programme is delivered by staff from HMP Coldingley's team. The accredited Bridge Programme is delivered by a peripatetic Forward Trust team which delivers the same programme across several prisons. Those staff are not considered in the above reckoning of the psychosocial complement at HMP Coldingley. This is a good spectrum of structured and group interventions.

Guidance from Public Health England (PHE) highlights the significance of mutual aid groups in custodial settings.³⁸ Prior to covid-19, Alcoholics Anonymous (AA) provided two sessions in the prison per week and Narcotics Anonymous (NA) provided another. These are all currently suspended. There is a risk that turnover in sponsors may mean that they do not start again promptly once covid-19 is no longer an issue.

The prison is in the process of developing plans for an incentivised substance free living wing (ISFL) where men who are motivated to address their substance misuse issues are located together and support each other in their recovery journey. At the time of writing (December 2020) it was clear that the core of this wing would be people with a substance misuse history who wanted to remain abstinent and avoid substance use, but it was not yet clear what other types of residents would be making up the population of the rest of the wing. This is a crucial issue as placing the 'wrong' type of residents in such units has been a significant contributing factor in them failing to fulfil their potential, and probably why the previous attempt, focused on just one landing, at HMP Coldingley was unsuccessful.

It was also not yet clear what, if any, extra resources might be needed to support the population of such a wing. Many of the substance misusers involved would already be receiving substance misuse services, so extra resources would probably not be needed for these residents unless additional interventions are proposed. If this wing does end up with a significantly more therapeutic environment than the rest of the prison, we would recommend that the core uniform staff team is kept as stable as possible, receives appropriate training, and ideally staff have chosen to work on that wing.

Most of the team's psychosocial provision is one-to-one and focused on care planning and harm and risk-reduction, i.e. it tends to be short-term and focused on key milestones such as release or relapse or other incidents.

It has long been recognised that at least some substance misuse is driven by trauma, and though historically substance misuse services used to provide longer-term therapeutic

³⁸ PHE (2018) [Unlocking the potential of mutual aid in prisons](#). (accessed December 2020).

interventions, this has been discouraged over the last two decades in favour of a case management and risk-reduction model. More recently, both prison and healthcare staff have become more aware of the impact of trauma and how this underlies much ill-health, and there is an openness to addressing these issues. There are broadly speaking two complementary approaches, both dependent on resources. Firstly, there is no reason for substance misuse to act as an exclusion criteria for specialist psychological interventions, as long as the person is 'sober' enough to engage, i.e. substance misuse could work in partnership with psychology, particularly where the issue is complex. The complementary option is for substance misuse staff to provide longer-term therapeutic counselling.

Recommendation 23: Develop pathways for longer-term therapeutic interventions for substance misusers.

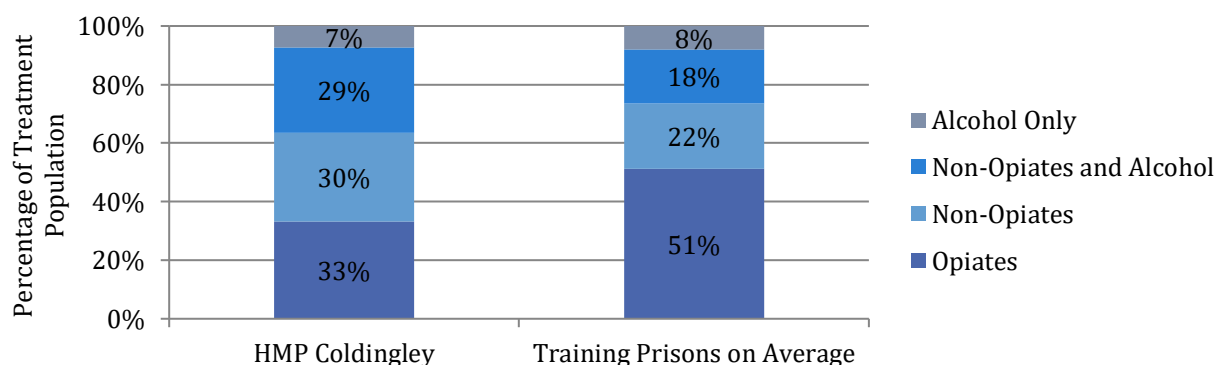
There had been a substance misuse gym session, but this was not as popular as hoped, perhaps as it was not adapted enough to the motivations and abilities of the people concerned. The team would like to try this again.

There is a monthly drug strategy meeting that covers supply and demand reduction and recovery. The meeting is action focused and those involved felt it worked well, although the drug strategy lead felt that tasks still tended to fall to the specialists, whereas many would ideally have been mainstreamed. In this respect, considerable effort had been put into engaging the uniform staff in understanding and support the drug strategy agenda. The drug strategy is currently being reviewed, though we are told that the existing one was already considered a model of good practice and is comprehensive in all three areas of supply reduction, demand reduction, and recovery.

6.4 Service Activity

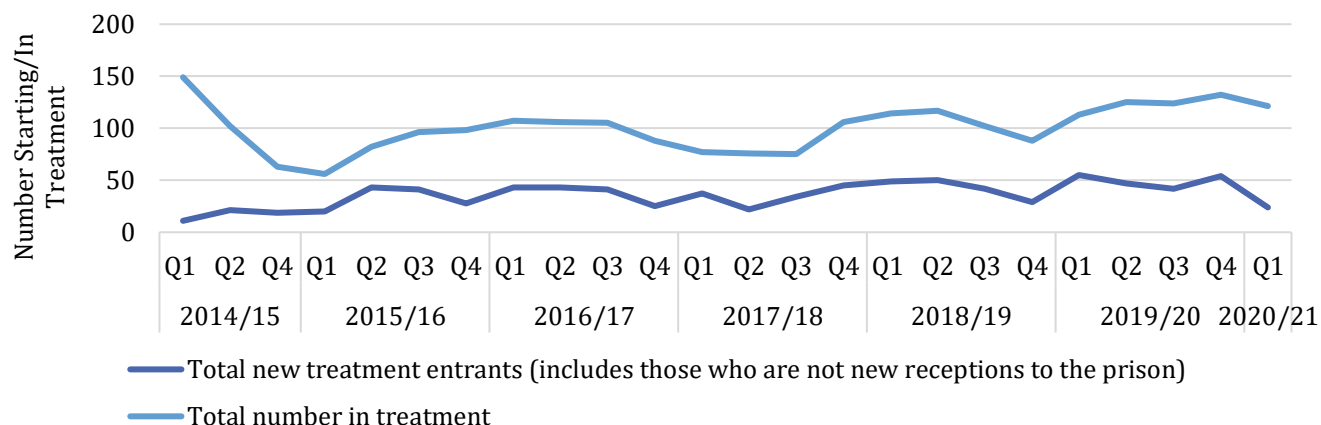
The substance use profile, as reported on NDTMS, of those in treatment at HMP Coldingley is much more weighted towards non-opiate use compared to training prisons on average, with just 33% of patients in treatment during 2019/20 being opiate users. The same pattern is visible among new patients entering treatment during 2019/20, of whom 32% were opiate users and the majority (61%) were users of non-opiate drugs, either with or without alcohol.

Figure 72 – Substance Use Profile of Patients in Treatment (NDTMS data, 2019/20)



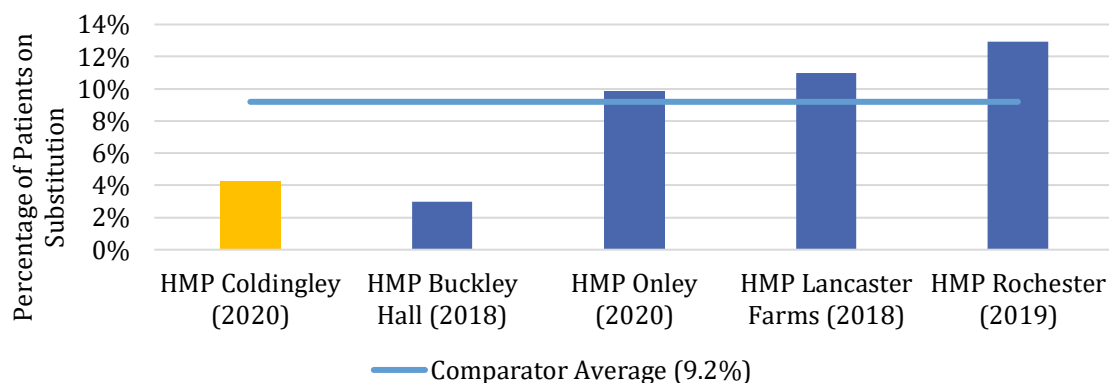
Data relating to the current and historic in-treatment population was taken from NDTMS (most data relates to the full year 2019/20). The chart below describes numbers in treatment from 2014/15 to present and includes figures for new entrants and total numbers in treatment. There has been a decline in the recorded numbers of new entrants in the first quarter of 2020/21, since covid-19.

Figure 73 – Substance Misuse Treatment – New Referrals and Numbers in Treatment (NDTMS)³⁹



Service data supports the view of the population at HMP Coldingley largely being at the less risky end of the substance misusing continuum; with just 4.3% of patients in treatment at an October 2020 snapshot receiving opioid substitution interventions (n=19) – lower than most comparators for which this data was available. Note that this is similarly low to HMP Buckley Hall, another working prison, whereas the other comparators are not. This may support the hypothesis that a significant substance misuse history might act against a transfer to a working prison. This low number may partially be because, historically, the prison had a low cap on OST numbers and some of the sending prisons may have thought of sending OST residents elsewhere first. However, the service reports that the OST number had risen recently.

Figure 74 – Opioid Substitution (service data)



Of the 19 patients prescribed OST at the October 2020 snapshot, almost all were reported to be on maintenance (with fewer than five patients on a reduction programme). The team reports that it moved to an explicitly patient-led approach (which tends to mean maintenance) in response to national good practice guidance. This guidance applies to all prisons (and to the community) but is open to some interpretation, i.e. many service providers in prison still actively and consistently encourage people on OST to reduce their medication with a view towards eventual abstinence, unless it is clear that this risks causing increased harm. Prison – and particularly a long stay in the same prison – is a good opportunity to end an addiction and spend some time learning to manage without that drug, and the proposed new wing could further support that level of recovery. There is, of course, a balance to be struck, and ultimately it is about whatever most helps reduce that person’s risk, though we would encourage more of a focus on recovery and eventual abstinence.

³⁹ Please note the NDTMS system was not operational for Q3 2014/15, so no data is available for this quarter.

Recommendation 24: Further develop a focus on OST reduction, cessation, and recovery.

NDTMS-reported intervention length at HMP Coldingley is somewhat shorter than the average for training prisons (101 days compared to 156 days on average).

6.5 Accessibility and DNA Rates

The prison was keen on a wing-based approach to engagement, as opposed to substance misuse waiting for people to come to them, and this is largely what happens with the 1:1 SMS interventions. Opioid substitution therapy administration needs to be centralised, but as most SMS interventions are 1:1 and do not require any equipment (only a private space), it should be possible to deliver much of this on the wings (see primary care [discussion](#)).

In the most recent six months available (April to September 2020, i.e. since covid-19), SystmOne reported an average DNA rate of 0% for substance misuse clinics. This had not changed from the previous six months (October 2019 to March 2020). Unlike some other clinics, substance misuse clinic activity did not appear to have reduced during the covid-19 pandemic – the average monthly number of appointments seen actually increased, from 463 appointments per month in October-March, to 552 appointments per month in April-September.

In the patient consultation, 63% of patients said they knew how to access substance misuse treatment and 17% had already done so. This is lower than at most similar prisons (67% of patients at HMP Rochester reported knowing how to access substance misuse services, as did 80% at HMP Buckley Hall and HMP Lancaster Farms, and 69% at HMP Onley). This is likely as more at HMP Coldingley did not feel they needed to know.

The prison refers any incidents of note - including information from intelligence reports – to the substance misuse staff who then contact the resident concerned to see if they want a service. Not all are willing to subsequently engage, although the drug strategy governor felt more could be done to challenge ‘denial’ and promote engagement.

6.6 Release Planning

The table below shows the areas reported by the service as the most common that men are released to; however, typical annual numbers are low. It is broadly similar to the picture for the wider prison, i.e. mostly the south-east and the issues involved are similar (see discussion on [Area of Home Residence](#)).

Figure 75 – Typical Home Areas for Substance Misuse Patients (treatment service data)

Area/City	Numbers per Year	Community Provider
Portsmouth	4	Society of St James
Hampshire	6	Inclusion
Southampton	3	CGL
Surrey	3	i-access
Bracknell Forest	3	New Hope

Staff report that there is normally plenty of time to plan for the person’s release or transfer, although most are transferred to cat D prisons. There is no particular preparation for the challenges of open conditions.

One or two a month are released on OST and staff report that there are never any problems in ensuring continuity. Men can be provided with their OST and/or FP10s as appropriate.

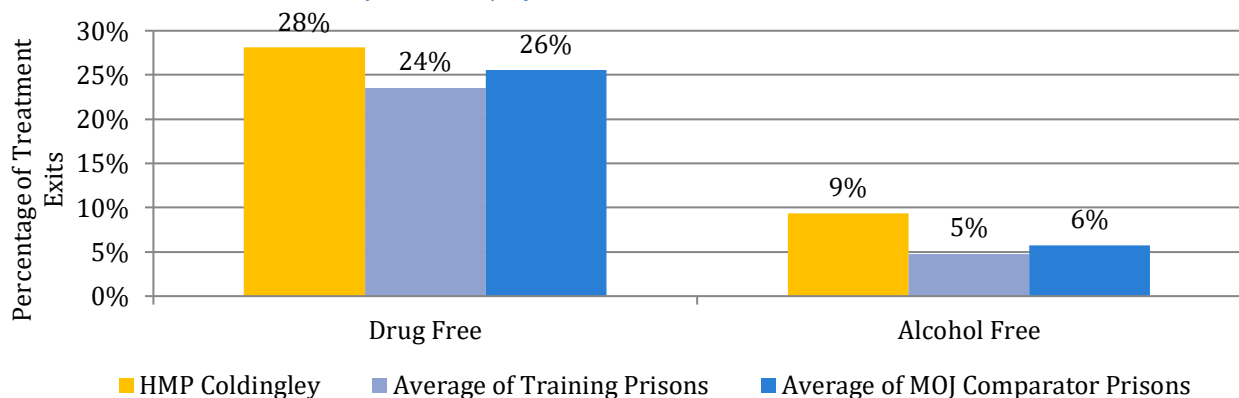
Naloxone can be provided to men on release. This is always accompanied by training on the use of naloxone and overdose prevention. This has continued throughout covid-19. Naltrexone is not commenced prior to release.

6.7 Treatment Outcomes

Caution needs to be taken when interpreting treatment outcome data as it relates solely to those who leave drug treatment (whether they choose to leave treatment, are released, or are transferred to another prison). A successful treatment outcome can include a discharge substance-free or with only occasional use, or an onward referral, for example to another prison or a community agency.

NDTMS reported that a high proportion (28%) of patients leaving treatment in HMP Coldingley left drug free in 2019/20 (just above the 2019/20 average of 26% across eight prisons selected from MOJ comparators, and 24% across all training prisons).⁴⁰ An above-average proportion also left treatment alcohol free.

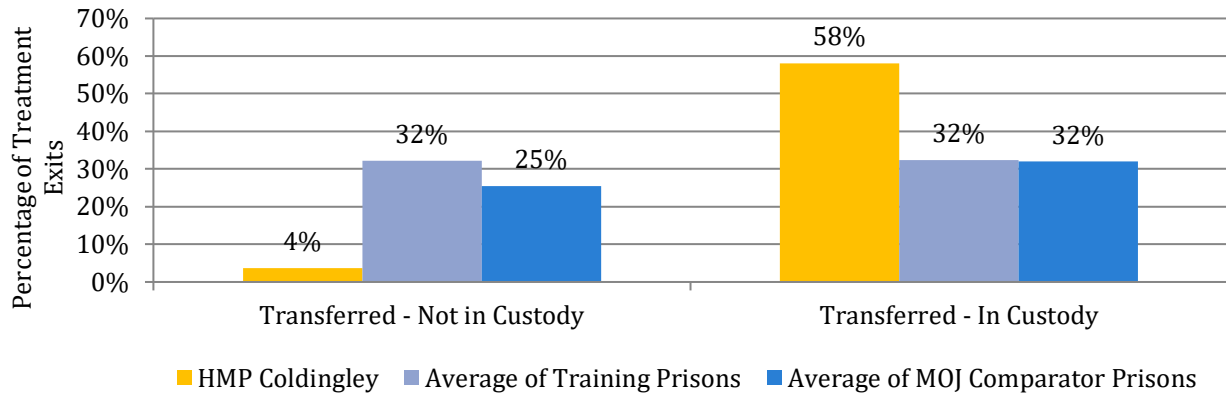
Figure 76 – Substance Free Treatment Exits (NDTMS, 2019/20)



A majority (58%) of treatment exits from HMP Coldingley in 2019/20 were reported by NDTMS to be of individuals who remain in treatment and were transferred to a substance misuse service in another prison. A much lower proportion were transferred to another treatment provider in the community.

⁴⁰ The comparator prisons included are: HMP Erlestoke, HMP Featherstone, HMP Haverigg, HMP Buckley Hall, HMP Guys Marsh, HMP Lancaster Farms, HMP Onley, and HMP Rochester.

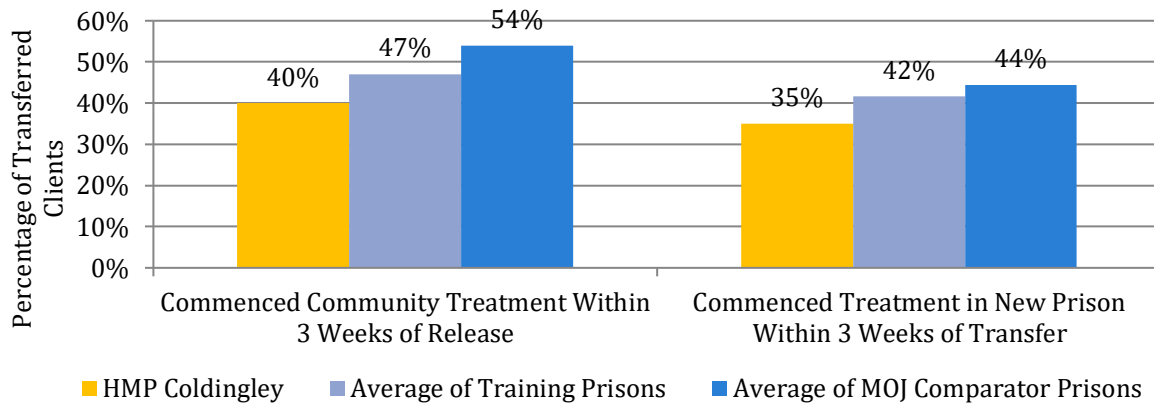
Figure 77 – Transfers to Continuing Treatment (NDTMS, 2019/20)



NDTMS data indicates that patients transferred from HMP Coldingley (either to treatment at another prison or to community services) were somewhat less likely to successfully pick up treatment at their new provider within three weeks than those from comparator prisons. This may be partly as Forward Trust only makes specific appointments on release for OST patients, not for those receiving psychosocial interventions, who are expected to make their own appointments. Staff report that many of the men feel like they have done all the substance misuse work they need to do and are not interested in doing any more, although this point will apply to many leaving cat C prisons. More could perhaps be done to encourage engagement with community services on release.

Recommendation 25: Increase engagement with community provision on release.

Figure 78 – Successful Transfers to Continuing Treatment (NDTMS, 2019/20)



Note that the numbers transferred to community treatment were so low that the percentage transferred within three weeks is largely meaningless.

6.8 Substance Use in the Prison

Mandatory drug testing ceased since covid-19, although the security governor felt the figures might under-represent illicit use anyway as a lot of residents refused the tests. A recent ‘throw-over’ find contained buprenorphine, and intelligence reports also mention illicit buprenorphine. This makes it more difficult to monitor diversion of legitimately prescribed buprenorphine.

Part B of the report contains much fuller information in relation to the impact of new psychoactive (NPS/PS) type drugs in prisons, and on prison healthcare teams in general.

NDTMS indicated that NPS/PS use in HMP Coldingley is similar to the national average, with 8% of patients in treatment during 2019/20 reporting primary use of NPS/PS drugs (twice the 4% of patients reporting primary NPS use in prisons nationally). Security reported that steroids and cannabis were also common.

Healthcare report that NPS is still on the prison risk register and, in the earlier days of its use, was a significant concern at HMP Coldingley, with half a dozen emergency codes some days. Use had already declined pre-covid-19 but remains an issue. Staff recognise that at least some of the NPS use is hidden and many of the incidents involved are managed in-cell by other residents without staff ever becoming involved. They report that the problems and risks tend to focus on one or two people rather than be widespread, and it is those people who are responsible for most of the code blues, etc.

HMP Coldingley appears to have a well-developed approach to supply reduction although the IMB⁴¹ raised concerns about the level of drugs and illicit alcohol and the consequences of this. There are nets to make throw-overs more difficult and the prison was an early adopter of testing and photocopying mail. The prison works closely with the local police and there has been creative use of police CCTV vans. There are two passive drug dogs. Cell searches are intelligence-led.

Covid-19 had a significant impact on substance use in the prison. Security and other staff report a significant drop in the availability and use of illicit drugs, and a concomitant rise in the production and use of illicit alcohol. The use of illicit alcohol has been a concern at HMP Coldingley ever since the smoking ban (over 1,000 litres was found in 2019), but this appears to have increased even further since covid-19. The prison felt this was a significant problem and more needed to be done to address it, particularly over the Christmas period. Illicit drug use has slowly increased again, and staff have detected a direct relationship between the degree of lockdown and the availability and use of drugs. Additionally, the restriction on movement has impacted on the drug trade in the prison and, therefore, on all the other problems associated with this such as debt, bullying, etc.

The new governor is keen on a compact-based drug free wing supported by SMS and as separate as possible from the rest of the prison, including separate medicines administration (see [above](#)).

6.9 Recent Unexpected Deaths

In August 2018 a resident was found dead in his cell from psychoactive substance toxicity. The Prisons and Probation Ombudsman (PPO) report has yet to be published but the draft and the clinical review were positive about the ACCT processes involved and the SMS support and involvement. However, it did note that the lack of non-clinical substance misuse recording on SystmOne reduced the opportunity for comprehensive oversight of his clinical history and, therefore, for a coordinated approach to his care. It also felt that the record-keeping did not comply with General Medical Council and Nursing and Midwifery Council standards and needed to change, i.e. the psychosocial aspects of SMS work needed to also be reflected in the case records on SystmOne (see [Recommendation 22](#) above).

In October 2019, a separate resident was found dead in his cell at HMP Coldingley, possibly as a result of substance misuse. The post-mortem established cause of death as respiratory

⁴¹ IMB (2020) [Annual Report of the Independent Monitoring Board at HMP Coldingley 2019-2020](#) (accessed December 2020).

arrest, and toxicology did not show any drugs, although NPS use was suspected. He had a history of substance misuse, mental health problems, a learning disability and asthma. The PPO investigation has yet to be published, but the independent clinical review concluded that care was similar to what might be expected in the community. It was also noted that the substance misuse services had been responsive and proactive in engaging with him. Several recommendations were made, most of which are either to do with standards of record-keeping or echoed other recommendations made in this report.

6.10 Chapter Summary

- The substance use profile of HMP Coldingley is different to the usual profile for training and resettlement prisons with a lower proportion of substance misuse problems in general and a lower severity of types of substance use.
- Despite lower levels of need, the substance misuse service is better than comparators at engaging people in treatment, particularly drinkers.
- Clinical staffing is broadly adequate though vulnerable to absence. Psychosocial staffing is broadly similar to comparators and perhaps sufficient to meet most need.
- The provision includes a good range of group work.
- Provision has continued well under covid-19.
- Trauma issues often underlie and drive substance misuse and may require longer-term interventions to address (see **Recommendation 23**).
- The substance misuse strategy framework is good and works well.
- Most OST patients are maintained rather than reducing (see **Recommendation 24**).
- Releases into the community are few but are easy to plan for. Naloxone is provided where relevant.
- Levels of engagement with community services are well below national averages (see **Recommendation 25**).
- There is a well-developed strategy to reduce supply. Covid-19 has led to a reduction in illicit drug use but an increase in illicit alcohol use.

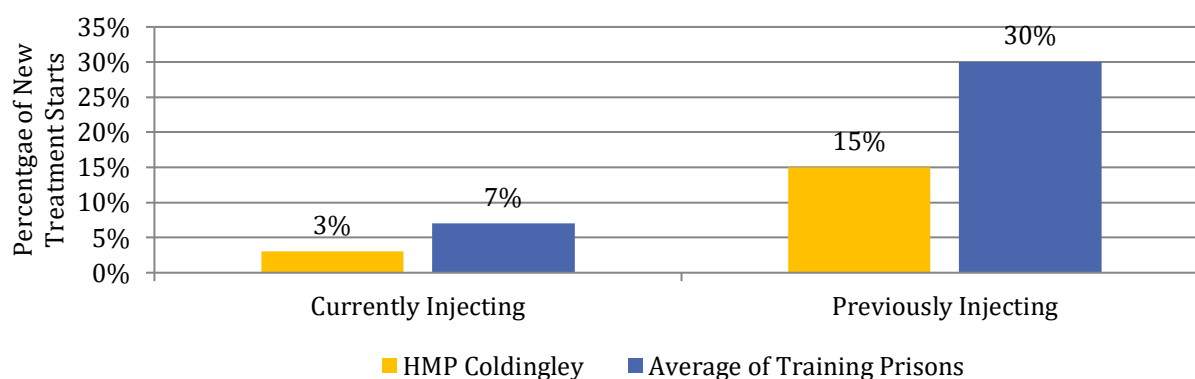
Chapter Seven – Communicable Diseases

7.1 Blood Borne Viruses (BBV) – Screening

In some of this chapter there are three different sources for the same data: NDTMS, HJIPs and SystemOne. These rarely produce the same figures, and in some cases these are very different. A further challenge is some confusion between 'screening' and 'test' as part of the read code, as it is clear that in some cases the number in the data refers to 'screens', in the sense of a question that may lead to an intervention, and in other cases a 'screen' means an actual intervention, such as a blood test. These differences are discussed, and judgements made as to what are the most likely figures and what the implications of these might be. Additionally, some of the codes in the tables below have been renamed so the data presented is easier to understand, e.g. 'test' as 'screen' when the latter is what is meant.

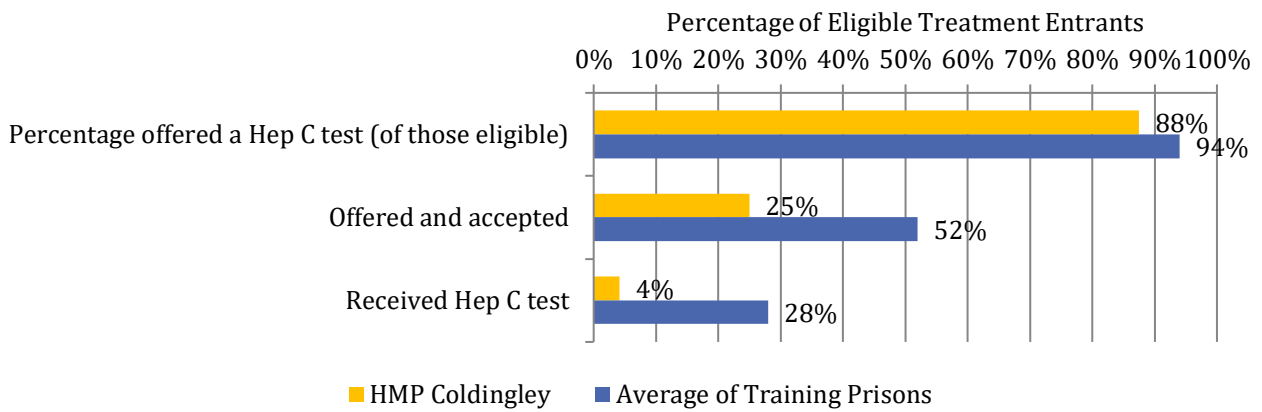
NDTMS data describes the proportion of residents starting substance misuse treatment who have previously injected and who are currently injecting. This is important as it is an indicator of likely need in relation to BBVs. The data presented below in the figure below covers the whole of 2019/20. As can be seen, HMP Coldingley has relatively low rates of substance misuse treatment entrants currently injecting or having previously injected, compared to the national average for training prisons.

Figure 79 – NDTMS Injecting Rates amongst Drug Users (2019/20)



NDTMS data also shows those entering drug treatment who are eligible for blood borne virus (BBV) interventions. A below-average proportion of the eligible patients were reported as being offered, accepting, and receiving hepatitis C screening at HMP Coldingley. The head of healthcare felt that this was partly because many of the men had already been screened at their previous prison and uptake at HMP Coldingley was subsequently low, however, this argument applies to all training prisons. Healthcare felt that more could be done to reduce the drop-off between those who accepted tests and those who received them. Substance misuse would likely also have a part in improving take up of Hep C testing. The low take-up and low numbers involved may explain why there are so few Hep C test results recorded on SystemOne. Similar issues apply for other BBVs (i.e. Hep B and HIV, not TB).

Figure 80 – NDTMS Hep C Screening Data (2019/20)



Recommendation 26: Primary care and SMS to work together to support increased testing for BBVs and take up of HBV vaccination, adopting MECC (making every contact count) principles and ensuring accurate record keeping.

The numbers recorded on SystmOne as receiving BBV screenings during 2019/20 and April to September 2020 are shown below. Around 48-49% of all residents spending time in HMP Coldingley during 2019/20 were offered testing for at least one blood borne virus, with around 15-17% recorded as having been tested (the proportion recorded as tested varied slightly depending on the virus). Note this is higher than the NDTMS numbers tested above. During April to September 2020, 26% of residents were offered testing for BBVs and 3-5% were recorded as having been tested, in other words covid-19 has led to a drop in opportunity and take up of testing, hopefully temporary.

Perhaps the most important aspects of this information are the numbers identified as positive. The percentages shown are of the total number tested for each condition. Very low numbers were recorded as having a positive test for any virus. On the other hand, few negative results were recorded either. Primary care thought this was probably a recording and/or coding issue. Note that people are being offered DBST for BBVs in general, rather than for specific BBVs, which is why the numbers offered and declined are the same for all three BBVs.

Figure 81 – Screening Activity (SystemOne data)

HMP Coldingley	2019/20	2020/21 (April-September)
HIV		
HIV test offered	417	149
HIV screening declined	303	131
HIV screening test	125	19
HIV positive	<5	<5
Hepatitis C		
Hepatitis C screening offered	418	150
Hepatitis C screening declined	304	131
Hepatitis C screening/test	125	18
Hepatitis C screening positive	0 (0.0%)	0 (0.0%)
Hepatitis C antibody test	16	9
Hepatitis C antibody test positive	0 (0.0%)	0 (0.0%)
Hepatitis B		
Hepatitis B screening offered	418	149
Hepatitis B screening declined	303	130
Hepatitis B screening test	142	28
Hepatitis B screening positive	0 (0.0%)	0 (0.0%)

As is clear, a lot of people refuse testing, anecdotally this is usually because they have already done them rather than they think they are irrelevant.

HJIP reports also provided some information on BBV testing; a summary of 2019/20 data is presented below. The numbers vary slightly from those above but show a similar drop off at all the stages towards a test.

Figure 82 – Screening Activity (HJIP data)

HMP Coldingley	Average per Month Apr-19 to Mar-20	Total Apr-19 to Mar-20
HIV		
HIV eligible (new receptions/transfers not already confirmed positive)	38	
Patients offered testing	33 (88%)	398
Patients who have been tested	12 (31%)	140
Patients with a confirmed diagnosis of HIV	0	0 (0%)
Hepatitis C: New Receptions		
Hep C eligible (new receptions/transfers not previously tested/treated)	38	
New receptions offered Hep C testing	34 (90%)	405
New receptions undertaking HCV antibody testing	9 (24%)	108
Patients with positive HCV antibody test (at reception screen)	0	0 (0%)
Hepatitis C: Whole Population		
Hep C eligible (whole population)	442	
Offered Hep C testing (whole population)	37 (8%)	438
Undertaking HCV antibody testing (whole population)	11 (2%)	128
Patients with positive HCV antibody test (whole population)	0	0 (0%)
Hepatitis B		
Hep B eligible (new receptions/transfers)	18	
Patients offered testing	17 (94%)	199
Positive and referred to specialist service	0	0

SystemOne and HJIP data show somewhat different numbers screened in 2019/20; of note is the relatively low (compared to SystemOne) numbers described as tested for hepatitis B in HJIP reporting. This may be because HJIPs focus only on patients meeting eligibility criteria, while SystemOne will report on all patients screened. SystemOne describes very low numbers identified with BBVs during the year, while HJIP describes none.

At an October 2020 snapshot, SystemOne indicated fewer than five patients with a recorded HIV positive diagnosis (<1.1% of the population). Fewer than five patients at snapshot had a positive test result for Hep B on record (<1.1%), and six patients (1.3%) had a record of a positive Hep C PCR test (17 or 3.8% had a positive Hep C screening on record). To put this in context, PHE estimates that 0.3% of the prison population is living with HIV, and 9% with HCV (as described in Part B).⁴²

In terms of meeting need, it appears that there are appropriate levels of offers of testing. The levels of acceptance of that offer appear significantly lower than other training prisons, so there may be more that can be done to ‘sell’ testing. There appears to be a significant drop towards the numbers receiving the results of a test upon which any future intervention decision would normally rest. It is likely that this drop-off is at least partially a record-keeping issue. As such, it is hard to be clear on the extent to which the need to know the result of BBV tests may be being met, i.e. the extent to which any BBV is identified, or for that matter whether risky behaviour has been explored. Therefore, we have to conclude that the need around BBVs may be only partially met and more should be done to increase take up of testing (and improve associated record-keeping), as already recommended above.

⁴² PHE (2015) *Blood-borne Virus Opt-Out Testing in Prisons: Preliminary Evaluation of Pathfinder Programme. Phase 1, April to September 2014.*

7.1.1 Blood Borne Viruses – Pathway

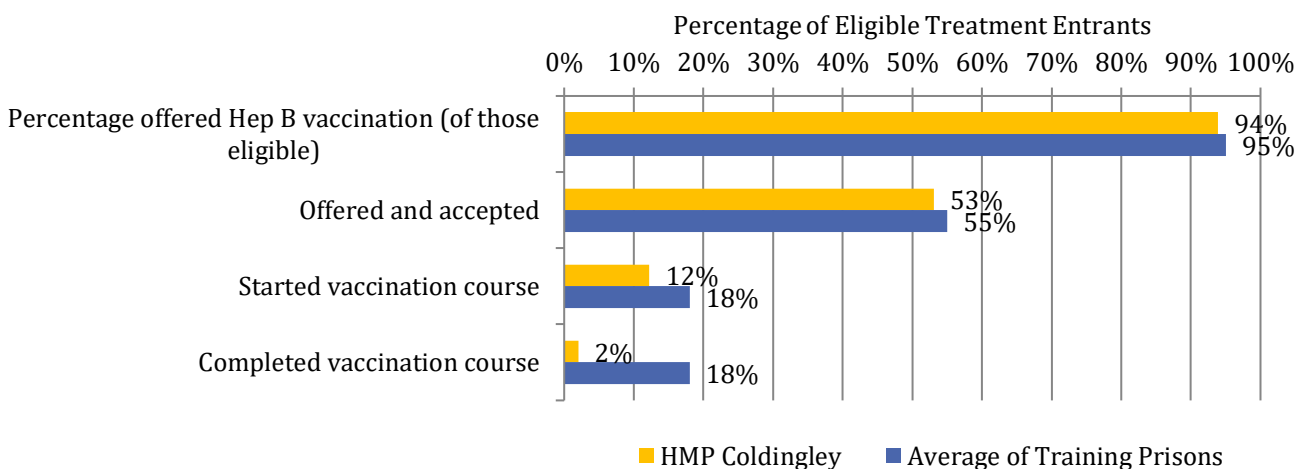
The GP felt BBV screening was good. Screening was usually by dry blood spot testing on an opt-in basis, i.e. the opportunity was offered. Primary care reported that many men often refused the offer on the basis that they had done this at a previous prison, though the trend towards men arriving at HMP Coldingley earlier in the course of their sentences may mean less will have had, or taken up, such offers. Ideally, any previous screens would be checked and any results etc. noted on SystemOne. Some prisons have found that an opt-out approach to DBST and screening increases take up, i.e. the default assumption is that the person is having the screen, unless they say otherwise.

Healthcare staff felt that the pathways were good into secondary care, particularly in relation to the community sexual health service and its consultant (this view was echoed across the other Surrey prisons). Forward Trust has access to the Hep C Trust. Sexual health and provision is discussed further [below](#).

7.1.2 Blood Borne Viruses – Vaccinations

NDTMS data shows a close to average proportion (of those entering drug treatment) offered and accepting a Hep B vaccination. The rate drops for those starting courses of vaccination and falls to 2% (the national average is 18%) for those completing a course.

Figure 83 – NDTMS Hepatitis B Vaccination Data (2019/20)



The HJIP reports cover the monthly numbers of patients eligible for, and receiving, hepatitis B immunisations. Between April 2019 and March 2020, an average of six patients per month were reported as eligible. HJIP reports indicated six patients in total receiving the full three doses of the vaccine during the year, an average of 9.1% per month of those eligible. It is not clear how many of these were carried over between months and how many were repeat decliners. The lack of information on declines in HJIPs makes it particularly difficult to assess the effectiveness of the processes involved.

SystemOne data described greater numbers vaccinated during 2019/20, with 48 patients recorded as receiving a third vaccine dose, and 25 a booster dose. This is a much more positive picture than that arising from the HJIP and NDTMS data and suggests that at least as far as HBV vaccination is concerned, some of the need is being met. All in all however, we feel that there is probably more that can be done to meet the need around most of the BBVs, particularly for testing.

7.2 National Immunisation Schedule (NIS)

The HJIP reports cover the monthly numbers of patients eligible for, and receiving, certain immunisations. These are presented in the following table.

Figure 84 – Immunisations and Vaccinations (HJIP data)

HMP Coldingley	Average per Month Apr-19 to Mar-20			Total Number Vaccinated Apr-19 to Mar-20
	Number Eligible	Number Vaccinated	Percentage of Eligible Vaccinated	
Flu vaccinations	27	5	18%	57
MMR	7	0	6%	5
Men ACWY	19	1	6%	13
Shingles	1	0	15%	2
TD/IPV	153	0	0%	2
Hep A	11	0	0%	0
Pneumococcal	78	0	0%	0

Primary care reports that all eligible residents are offered flu vaccinations but many decline, anecdotally at least a third. There is perhaps more that can be done to ‘sell’ the flu vaccine and perhaps vaccines in general (see recommendation below re covid-19). The pathways and close monitoring suggest most eligible people will likely be being offered a flu vaccination, although it is not possible to know exactly what factors have contributed to the shortfall in numbers, as these appear to be a lot more than a third. Discussions with CNWL’s performance lead around flu vaccinations highlighted variation in practice, recording, and in approaches to monitoring. CNWL is trying to establish consistency, but until this happens, everyone is reliant on HJIP data and analysis of pathways. Our conclusion is that most eligible people are probably being offered flu vaccinations, but a significant number are refusing them, even during covid-19, i.e. need is being met as much as is practicably possible, but there is still unmet need.

HJIP offers context that the rates of performance described above are not unusually negative compared to the broad picture across the prison estate. It should also be noted that while HJIP reporting only considers a patient to be vaccinated once all doses are received (for example the MMR (measles, mumps and rubella) vaccination requires two doses and hepatitis B requires three), those receiving a single dose before being released or transferred will still benefit from partial protection. Those leaving the prison having received one dose will be able to complete the immunisation elsewhere, provided the initial dose is properly recorded.

Some data regarding NIS vaccinations given was available from SystmOne for 2019/20 and 2020/21; this shows similar numbers receiving an influenza vaccination compared to HJIP figures, and a few more receiving MMR.

Figure 85 – National Immunisation Schedule Vaccinations (SystemOne data)

Vaccination Type (HMP Coldingley)	2019/20	2020/21 (April-September)
Diphtheria, Tetanus and Poliomyelitis 1	6	4
Diphtheria, Tetanus and Poliomyelitis booster	0	0
Influenza 1	55	0
Meningococcal group 1	11	2
MMR 1	9	1
MMR booster	1	1
Pneumococcal diseases 1	0	1
Shingles 1	2	0

Staff reported several residents who refused flu and other vaccinations and were intending to refuse any vaccination for covid-19. This would likely mean that such residents would continue in a restricted regime for some time, and possibly have to change cell in order to concentrate the risk in a form of reverse cohort unit. These negative consequences may encourage some of the currently resistant to vaccinate, but we suggest that prison and healthcare plan together how to promote maximum take up of any covid-19 vaccine, perhaps with resident input into the planning.

Recommendation 27: Ensure maximum take up of any covid-19 vaccine.

7.3 Sexual Health

HJIP reports an average of eight patients per month eligible for chlamydia screening 2019/20, and 24 patients in total reported as screened (on average this is 26% of eligible patients screened each month), however, it is again unclear how many are carried over each month and how many are repeat decliners. SystemOne reporting on chlamydia screening indicated 12 patients receiving screening over the course of 2019/20. Primary care reports that most refuse sexual health screening as they have been screened in their previous prisons, and this is borne out by the data below. Ideally, the existence of a previous screen (and any result) would be recorded on SystemOne, most appropriately by the previous prison, and reflected in the HMP Coldingley notes.

Figure 86 – Sexual Health Screenings (SystemOne data)

HMP Coldingley	2019/20	2020/21 (April-September)
Chlamydia test offered	149	130
Chlamydia screening declined	122	128
Chlamydia diagnostic test/screen	12	<5
Chlamydia test positive	0 (0%)	0 (0%)
Chlamydia test negative	7	0
Syphilis screening offered	179	138
Syphilis screening declined	95	122
Syphilis serology	20	23
Gonorrhoea screening declined	123	128
Test/screen for gonorrhoea	53	84
Gonorrhoea test positive	0 (0%)	0 (0%)
Gonorrhoea test negative	7	0
Referral to contraception and sexual health service	18	31

Where there have been screens, there does not always appear to be recording of the results of those screens, anecdotally these are nearly always negative.

There are monthly clinics from the local GUM service, and primary care hopes to be able to do more of this by telemedicine now that that has been set up. One of the nurses is also sexual health trained.

In terms of need, the sexual health pathways are good, particularly once a need is identified. What is less clear is the extent to which the need is identified in the first place, i.e. how effective is the screening? The data suggests that the offers are being made but few residents are taking the opportunity. What is not clear from the data is why, i.e. is this because they have already been screened? CNWL is grappling with this problem. In conclusion, we think the need is probably at least partially met, if not largely, but more could be done to identify need and more could be done to improve record-keeping and monitoring.

7.4 Tuberculosis

HJIP provides some data regarding screening for tuberculosis (TB), this is outlined below.

Figure 87 – TB Screening (HJIP data)

HMP Coldingley (Apr-19 to Mar-20)	Average per Month	Total in Reporting Period
TB eligible patients	38	Not possible to report
TB screening uptake	28 (73%)	332
TB positive	0	1
TB positive and referred	0	0
Receiving treatment	0	0

Primary care reports only having ever had one person with TB, and that had already been identified in a previous prison. Together with the relatively good rates of screening, we feel that need is probably largely identified and met.

7.5 Chapter Summary

- BBV data is somewhat confusing and there are discrepancies between SystemOne, HJIP and NDTMS data. Rates of BBV screening appear to be below the average for trainers nationally and show a large drop off at the point of testing. The same is true for HBV vaccinations (see **Recommendation 26**).
- Covid-19 appears to have led to a drop in offers and take up of BBV testing.
- Sexual health and BBV secondary care pathways and support are good. Identification of sexual health need and associated monitoring needs improving.
- The data is inconsistent, but figures for national immunisations appear low, e.g. for flu.
- Anecdotally, some residents may refuse any covid-19 vaccine (see **Recommendation 27**).
- TB screening and pathways appear appropriate.

Chapter Eight – National Screenings and NHS Checks

8.1 National Screening Programme

As noted in Part B, there are several elements of the national screening programme which are relevant to the adult prison population. Health and Justice Indicators of Performance (HJIPs) report on some data on screenings, which is set out below. The time period is 2019/20 as this is likely to be more typical, not least as covid-19 has made some screens more difficult to ensure.

Figure 88 – National Screening Data

HMP Coldingley	Total Number Screened Apr-19 to Mar-20	Comment
Abdominal aortic aneurysm (AAA) screening	<5	See AAA Screening . Screening should be at age 65. Numbers eligible are consistently low and are identified to primary care, though the annual screening may mean some are missed. Needs appear to be partially met.
Retinal screening	9	See Retinal Screening . Diabetic eye screening is recommended annually. Pathways appear good, though some may be being missed.
NHS prison health check	41	See Physical Health Checks . Age data for HMP Coldingley indicates 217 men in the relevant age group at an October 2020 snapshot, and 401 having spent time in the prison in 2019/20, although it was not clear what sentences these men were serving. HJIP describes four patients per month, on average, as eligible, and an average of three per month screened, thus indicating possible unmet need, though staff made a convincing case that this did not fully reflect the numbers seen. Twenty-six patients were reported as screened by HJIP during April-September 2020. The monitoring and pathways are such that we believe most need is likely met.
Bowel cancer screening	5	See Bowel cancer . There is education and good pathways, and some improvement in take up since the new test. Some unmet need remains.

CNWL employs a performance lead for the Surrey prisons and this post ensures that all the prison teams are aware when there is an upcoming need for any health check or review, and monitors that these have been done. Staff felt that the national monitoring was good. Pathways and the oversight monitoring were well developed and such that screening levels should be high, though this was not always reflected in the HJIP data, obliging us to note some areas of need as possible partially met.

8.2 Abdominal Aortic Aneurysm (AAA) Screening

AAA should be offered to a patient in their 65th year. CNWL's performance monitoring processes ensure primary care is aware when someone becomes eligible for AAA screening. SystemOne age data shows fewer than five men aged 65 at an October 2020 snapshot, and fewer than five having spent any time in the prison in 2019/20. HJIP indicates an average of two eligible patients per month, at least some of whom will have been carried over from previous months.

Primary care reports that the eligible numbers are consistently low and once a year (December) the eligible are reviewed. Annual screens make sense for low-risk and slower developing conditions but can mean patients are missed if they leave the prison before the annual review. Residents are sent out for ultrasound, although not since covid-19. As

residents are usually sent out for their screen it should not matter when they are sent out, i.e. the reviews could be designed to trigger when the person reaches 65, rather than wait until each December, and this might ensure more need is met. One person was screened during 19/20. Needs appear to be partially if not largely met, although some may be being missed if the patient is transferred/released in their 65th year.

8.3 Retinal Screening

Diabetic eye screening is recommended annually. Primary care reports retinal screening occurs twice a year, an appropriate frequency, but that sometimes this might be brought forward if indicated. The [Diabetes](#) section discusses pathways further and describes 21 men currently receiving treatment for diabetes; HJIP reports indicate an average of five men per month meeting eligibility criteria (with an average of one man per month screened). Note that if a patient is not screened in one month they will be 'carried over' and remain eligible the following month. No patients were reported as screened during April-September 2020. The data suggests a level of unmet need, including prior to covid-19, although the pathways and monitoring oversight appear appropriate. Needs appear to be partially if not largely met, although some may be being missed.

8.4 Physical Health Checks

The prison equivalent of the NHS Health Check, as it is known in the community, screens for vascular risk. The community equivalent targets those aged 40-74; responding to the premature ageing effect described in Part B, the prison health check targets those aged 35-74 serving two years or more. HJIP reports on the physical check for older individuals, describing 41 screens during 2019/20. Twenty-six patients were reported as screened by HJIP during April-September 2020. As discussed in the table above, we believe that most need in this respect is likely met.

The following table details the numbers of patients recorded on SystmOne during the last three and a half years as having had a number of the screenings that would normally be carried out as part of a five-yearly health check. Note that these figures are based on SystmOne read codes that would be recorded during a health check; it is likely that these read codes could also be recorded on an ad hoc basis and may, therefore, overestimate the numbers screened or identified via a formal health check. The monthly numbers recorded as screened do not appear to have reduced from April 2020 onwards, indicating screening activity is continuing, despite any restrictions due to the covid-19 pandemic.

Figure 89 – Rolling Five-Year Health Check Likely Screenings (SystmOne data)

	2017/18		2018/19		2019/20		April 20 to September 20	
	Total Screened	Average per Month	Total Screened	Average per Month	Total Screened	Average per Month	Total Screened	Average per Month
CVD risk assessment	35	3	14	1	12	1	8	2
Hypertension assessment	695	58	641	53	656	55	241	48
Atrial fibrillation assessment	224	19	160	13	172	14	96	19
Diabetes risk assessment	58	5	88	7	130	11	45	9
Chronic kidney disease risk assessment	319	27	317	26	320	27	136	27
Full alcohol risk assessment	128	11	2	0	9	1	5	1
Assessment for familial hypercholesterolemia	244	20	158	13	153	13	59	12

Some data was also available from SystmOne regarding the numbers of patients recorded as having received or declined an NHS Health Check over the past several years. This is shown below, with slightly lower numbers recorded during 2019/20 and 2020/21 to date compared to HJIP reporting. In addition, this data may include patients not considered by HJIP to be eligible for screening. This data reinforces our view that most of the checks are probably being done.

Figure 90 – Health Check Screenings (SystmOne data)

	2016/17	2017/18	2018/19	2019/20	2020/21
Number of patients with record of NHS Health Check completed	1 (0%)	184 (21%)	38 (4%)	35 (4%)	19 (3%)
Number of patients with record of NHS Health Check declined	0 (0%)	35 (4%)	9 (1%)	7 (1%)	1 (0%)
Number of patients with record for Well Man screening	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

8.5 Bowel Cancer Screening

Screening should be offered every two years for those aged 60-74. SystmOne data indicates 13 patients in this age group at an October 2020 snapshot, and 24 having spent time in the prison in 2019/20. HJIPs show an average of five patients per month as eligible, and five screened in 2019/20 (a further two patients were screened during April-September 2020).

There is a lead nurse for bowel screening and the GP felt this pathway was effective and not reflected accurately in the HJIP data. Staff reported that there were some men unwilling to be screened, although the new faecal immunochemical test (FIT) test was proving more acceptable. The lack of in-cell sanitation in two-thirds of the cells (i.e. no toilet or sink) is very likely a contributory factor for refusals. There is health promotion on the topic and there appears to be a good pathway, so it appears that what could be done to promote bowel cancer screening largely is being done. It is hard to be certain as to the level of unmet need, although there is clearly some.

8.6 Chapter Summary

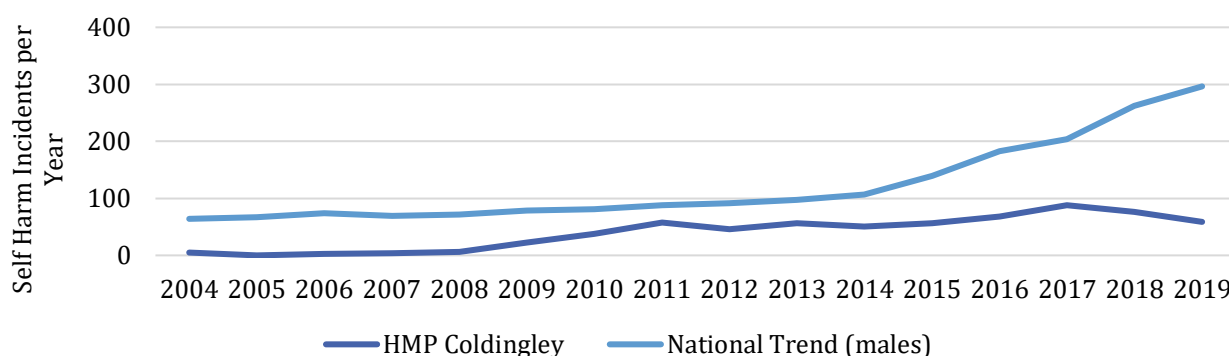
- Needs for abdominal aortic aneurysm screening and diabetic retinopathy screening appear to be partially if not largely met.
- The physical health checks appear to largely be taking place as needed.
- The need for bowel cancer screening is not fully met, although it is difficult to know what else primary care could do to improve this.

Chapter Nine – Self-Harm and Self-Inflicted Deaths

9.1 Self-Harm

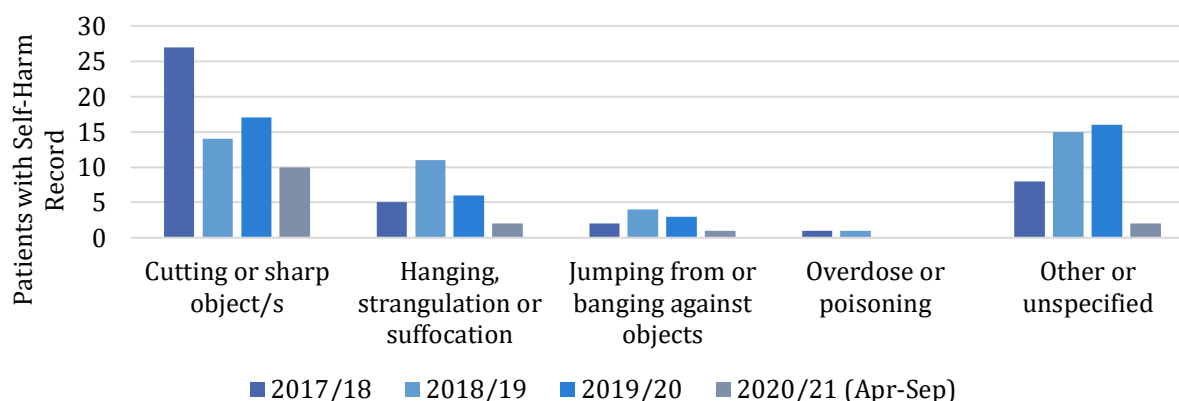
Self-harm incidents at HMP Coldingley (shown below; the national trend line is standardised for a population the size of HMP Coldingley), have increased in numbers but much more slowly than the national trend, even decreasing in the last two years.

Figure 91 – Self-Harm in HMP Coldingley (comparison)⁴³



In some cases, high numbers of self-harm incidents may indicate a number of individuals engaging in these behaviours; in other circumstances, a small number of prolific self-harmers may account for a large proportion of the incidents reported. MOJ data no longer includes the number of patients recorded as having self-harmed in each prison; SystemOne data indicates that during the full year 2019/20, 32 patients were recorded as having self-harmed, and 11 during 2020/21 so far (to September). This appears to have remained at the same level over time (with 32 patients having a recorded self-harm incident during 2018/19, and 30 in 2017/18). The 32 patients in 2019/20 had a total of 42 incidents recorded. This suggests that in HMP Coldingley, relatively few self-harmers had multiple incidents recorded.

Figure 92 – Types of Recorded Self-Harm (SystemOne data)



SystemOne data regarding the types of self-harm suggested that cutting or self-harm with sharp objects was consistently the most common method over the past few years. Data from the safer custody team showed the same pattern, with most (43-49%) incidents between 2017/18 and 2019/20 being reported as cutting. As with SystemOne data, safer custody data reported hanging or strangulation as the next most prevalent type of self-injury.

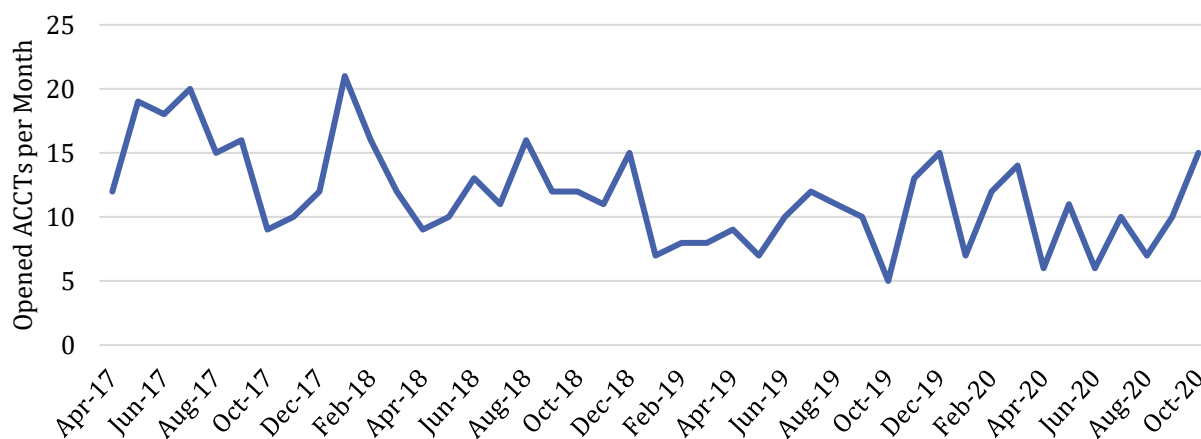
⁴³ MOJ (2020) [Safety in custody statistics](#). Table 9a: Self-harm incidents^{1,2} by month, year and prison, 2004 - December 2019, England and Wales.

9.2 Assessment, Care in Custody, and Teamwork (ACCT)

Anecdotally, staff report that the number of ACCTs open at any one time at HMP Coldingley rarely reaches double figures and on occasions is zero, more usually between three and five.

Data provided by the safer custody team at HMP Coldingley shows that numbers of ACCTs have decreased over the past three years, with an average of 15 per month opened during 2017/18, 11 per month on average during 2018/19, and 10 per month on average during 2019/20.

Figure 93 – Opened ACCTs (safer custody data)



Mental health usually attends ACCT reviews, primary care may attend on the weekend (when there are no mental health staff), but outside of normal office hours there may be times when there is no healthcare attendance for an ACCT meeting, although this is rare. The case managers ensure attendance and healthcare checks the daily briefings. Everyone reports that this usually works well.

There is a weekly safety interventions meeting overseeing the ACCTs and some of the more complex residents, particularly the 'dual harmers' who are a risk to themselves and to others. Healthcare always attends this meeting, usually both mental health and primary care.

If someone on an ACCT is being considered for segregation, there is a multi-agency risk form that evidences that all other options have been considered, although healthcare will not be able to input into this outside of its working hours.

9.3 Self-Inflicted Deaths

Since 2005 there have been two self-inflicted deaths at HMP Coldingley, one in July 2017, the other in September 2018. None have been reported since. This is fairly similar to the national rate, standardised for a population the size of HMP Coldingley.

The report⁴⁴ into the 2017 death made several recommendations about the ACCT process, about residents on an ACCT being held in segregation, and on aspects of mental health care. The consequent action plan⁴⁵ addresses all the issues raised and the changes made appear to still be in place. The one area that remained unclear was the issue of how a mental health

⁴⁴ PPO (2020) [Independent investigation into the death of DD a prisoner at HMP Coldingley on 8 July 2017](#) (accessed December 2020).

⁴⁵ PPO (2020) [Action plan relating to death of DD at HMP Coldingley 8 July 2017](#) (accessed December 2020).

assessment could be ensured for someone on an ACCT placed in segregation on the weekend, when there are no mental health staff. This does not appear to have been resolved in the manner outlined in the action plan, i.e. the only apparent route available would be out-of-hours provision. Whether this would be likely to lead to a specialist mental health assessment would depend a lot on when this happened, i.e. if it was when primary care was on duty then advice and support could be sought from within the CNWL structure, outside of those hours the uniform staff would be on their own and reliant on OOH cover, which may not lead to a specialist assessment. The report⁴⁶ on the more recent death had no recommendations relating to the ACCT process.

Deaths believed to be from natural causes are discussed in [Chapter Four](#). The most recent death in HMP Coldingley (not believed to be self-inflicted) is discussed separately in [Chapter Six](#).

9.4 Chapter Summary

- In contrast to the national trend of increasing self-harm rates, those at HMP Coldingley are low and have been steadily reducing since 2017.
- The number of ACCTs is consistently low, usually under five open.
- ACCTs work well. Mental health usually attends, sometimes other healthcare staff.
- The multi-agency weekly safer interventions meeting oversees the ACCTs and some of the more complex/risky residents.
- The most recent self-inflicted death at the prison was in 2018.

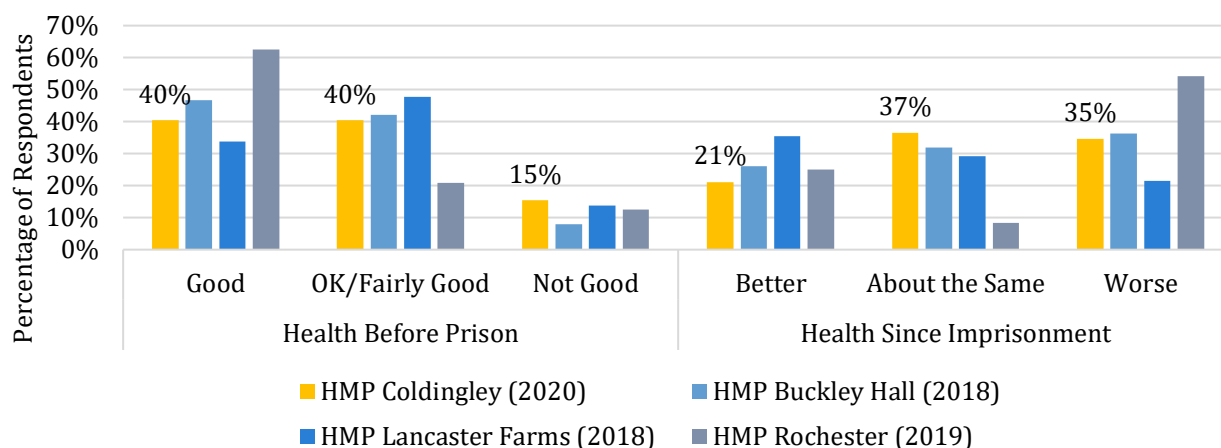
⁴⁶ PPO (2020) [Independent investigation into the death of JM a prisoner at HMP Coldingley on 13 September 2018](#) (Accessed December 2020).

Chapter Ten – Wellbeing and Health Promotion

10.1 Residents' Views

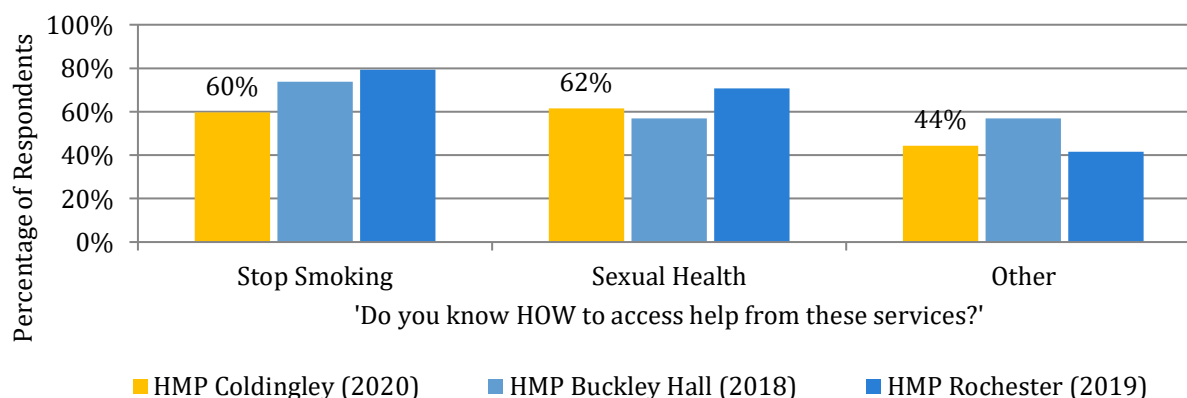
In our resident survey, respondents were asked about their health in general, prior to and since imprisonment. Respondents were slightly more likely than those at comparator prisons to say their health had been poor prior to imprisonment. The majority felt that their health was the same or worse since their imprisonment.

Figure 94 – Health Before Imprisonment and Now (survey data)



Residents were asked if they knew how to access health promotion services such as smoking cessation and sexual health, as well as 'other' services such as healthy living and weight management. Compared to other similar prisons with comparable data available, residents at HMP Coldingley appeared to be less confident in accessing these services.

Figure 95 – Accessibility of Health Promotion Services (survey data)



10.2 Generic Health Promotion

Staff reported a range of health promotion (e.g. posters, leaflets), particularly within healthcare, where most people normally came for their appointments. These are changed roughly monthly and have covered areas such as asthma, diabetes, sexual health, bowel cancer, BBVs, etc. Sometimes these tie into national health promotion efforts, sometimes they were patient or needs-led as an issue came to prominence. Additionally, most conversations with residents were an opportunity to promote healthy living, e.g. to discuss diet, weight, and

men's health. SMS does some health promotion in relation to information and harm-reduction advice, although could possibly do more. The prison emphasised the importance of considering literacy issues where health promotion was concerned.

The revised training course for the prison peer mentors has an element of health and wellbeing, although their work has been heavily undermined by covid-19 and the need to restrict movement between wings. The prison is moving towards a new structure for peer mentorship where there is a core training for all peer mentors and then they specialise on top of that, e.g. in substance misuse, health promotion, mental health, and so on.

Several people we spoke to felt that the process of coming out of the covid-19 restrictions might be a good opportunity for a drive on health promotion and healthy living, and this could usefully be steered by a multidisciplinary group involving healthcare (mental, physical and SMS), the gym, the kitchen and the prison. Other establishments have found such a group to be an effective driver of health promotion.

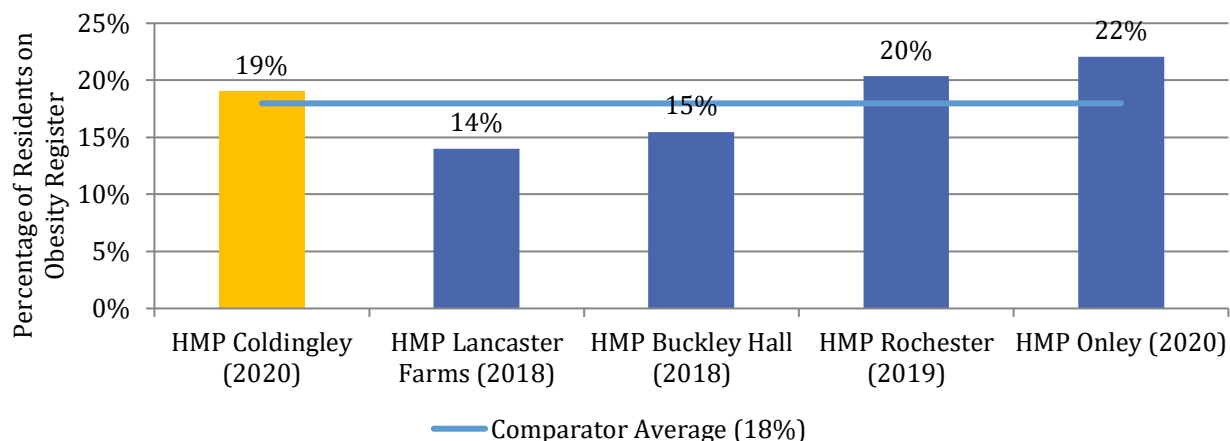
Recommendation 28: Establish a multi-agency group to support health promotion and healthy living.

10.3 Weight Management and Diet

There are two systems where weight is recorded; body mass index (BMI) records on SystemOne should report weight as taken at reception or subsequently updated, and QOF should record any patients where obesity is considered an issue. In theory, these two measures should match, although it is common to find some patients with a high BMI who are not on the QOF register.

At an October 2020 snapshot, 85 men (19%) were on the QOF register for obesity. This is average among comparator prisons for which this data was available.

Figure 96 – Percentage of Residents on QOF Obesity Register



At October 2020, SystemOne data indicated that 26% of BMI records showed patients with a BMI over 30, indicating obesity. A further 45% had a BMI indicating they were overweight, and fewer than five residents had a BMI indicating they were underweight. That is, nearly three-quarters of the prison are overweight.

Primary care and the GP felt that there were insufficient healthy options available from the kitchen. Several staff commented on the lack of healthy options available from the canteen, a

common complaint across all prisons. The diabetic nurse tries to educate the diabetic patients on dietary care but felt the impact was limited. The multi-agency group proposed above might be more able to make some headway on the several elements involved in the weight issue.

10.4 Fitness and Exercise and the Gym

There is an expectation that health promotion is embedded in everything the gym does, with universal and individualised attention to diet, fitness, exercise, and physical and emotional wellbeing.

Covid-19 had a significant impact on the gym and exercise opportunities. Over the summer there was a range of instructor-led activities outside, but the colder weather stopped these. At the time of writing (December 2020) the gym was due to reopen in a limited but safe way. Throughout covid-19, the Hub TV has shown exercise routines and advice for in-cell work, and the gym staff have developed a monthly magazine to support in-cell fitness.

As a working prison, there is a particular emphasis at HMP Coldingley on functional education that supports possible future employment, and the gym has its own classroom. The gym and education normally work together to deliver accredited qualifications up to level 3 (mostly at levels 1 and 2) for up to 50 learners a year, although covid-19 has heavily undermined this. There is also a healthy living course linked to employment. The catering courses (due to recommence soon) also have a significant component of dietary advice and information.

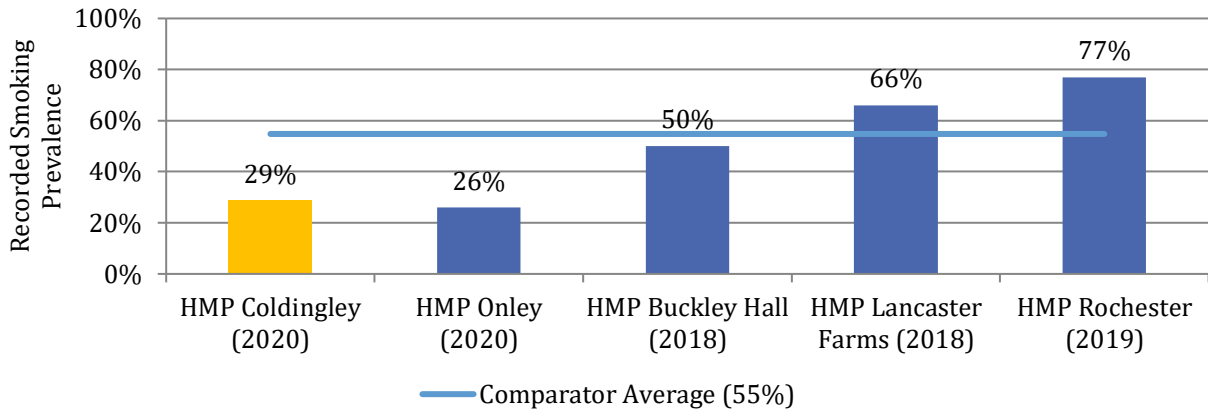
10.5 Smoking

HJIP reporting indicated that during 2019/20, an average of 12% of new receptions to the prison were reported as smokers and 74% of new receptions were users of electronic cigarettes. In the first six months of 2020/21 the rate of smokers increased to 25% and vapers reduced to 40%. These figures may be related and show people switching from identifying as smokers to identifying as vapers.

HJIP data showed that of patients identified as smokers during 2019/20 an average of 38% (21% in 2020/21 to date) were recorded as engaging in smoking cessation therapies, though due to the high numbers (457 in total), we suspect that in many cases this simply means switching to vaping. Of those referred to smoking cessation, 84% were reported as having been able to access support within 48 hours (this was not reported in 2020/21). In total, 23 patients were reported by HJIP to have been referred to smoking cessation treatment in 2019/20.

SystemOne data indicated that 29% of the prison population at an October 2020 snapshot were recorded as being smokers; it is possible the true figure may be even lower since this may include long-term patients who were recorded as smoking on entry and have since quit. This percentage is lower than most comparator establishments.

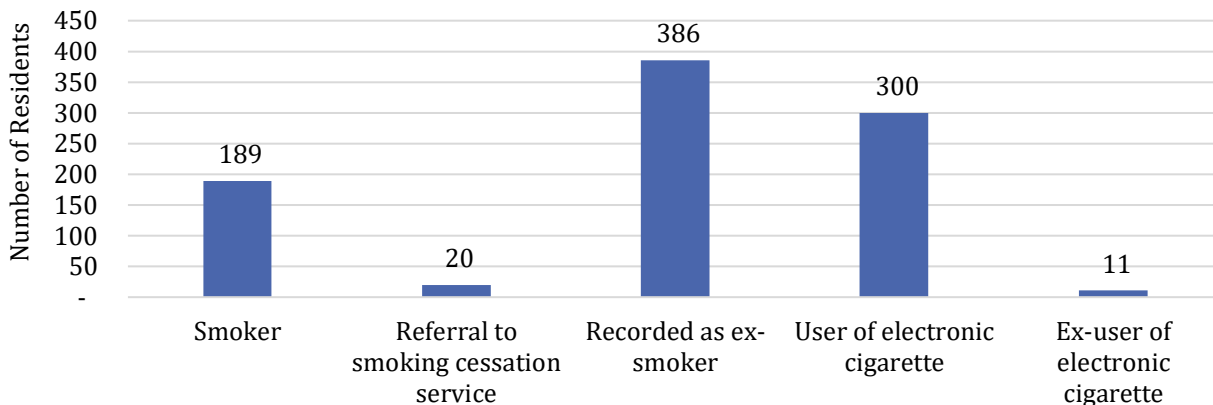
Figure 97 – Smoking Comparison (SystmOne snapshot data)



Fifty-two per cent in our survey said they currently used a vape or electronic cigarette – this was slightly above average (48% on average) next to the three comparators for which this information was available.

Uptake of smoking cessation intervention as reported by SystmOne is shown in the chart below. The number recorded as referred to smoking cessation is similar, but slightly lower, compared to that reported by HJIPs.

Figure 98 – Smoking Cessation Interventions (SystmOne data 2019/20)



Primary care reported that most active smoking cessation treatment had taken place in previous prisons, and that the use of nicotine replacement therapy (NRT) was rare at HMP Coldingley (NB, NRT is available from the canteen, also that NRT is not usually used for vapers). Their experience was that most residents who were vaping had little interest in reducing or stopping vaping, and that those who did stop were more likely to do it abruptly rather than through reducing. Primary care did not promote reduction or cessation of vaping.

Recommendation 29: Promote reduction and cessation of vaping.

In conclusion, many of the residents of HMP Coldingley were smokers, many of those now vape. Most who would want smoking cessation interventions such as NRT have already had them, though more could be done to reduce vaping.

10.6 Chapter Summary

- Most patients responding to our survey reported similar health prior to imprisonment.
- Primary care is active in health promotion across a range of topics. A multi-agency approach to healthy living would be beneficial (see **Recommendation 28**).
- Roughly a quarter of the prison population is obese and roughly three-quarters overweight.
- The gym does a lot to promote fitness and has done so throughout covid-19. The gym and education run several courses and qualifications with a fitness and health component.
- NRT is available, though most who want to stop have done in previous prisons.
- Half the prison uses electronic cigarettes (see **Recommendation 29**).

Chapter Eleven – Social Care

11.1 Overview

The Care Act 2014 sets out local authority duties in relation to assessing the needs of its residents and their eligibility for publicly funded care and support. Further information is included in Part B.

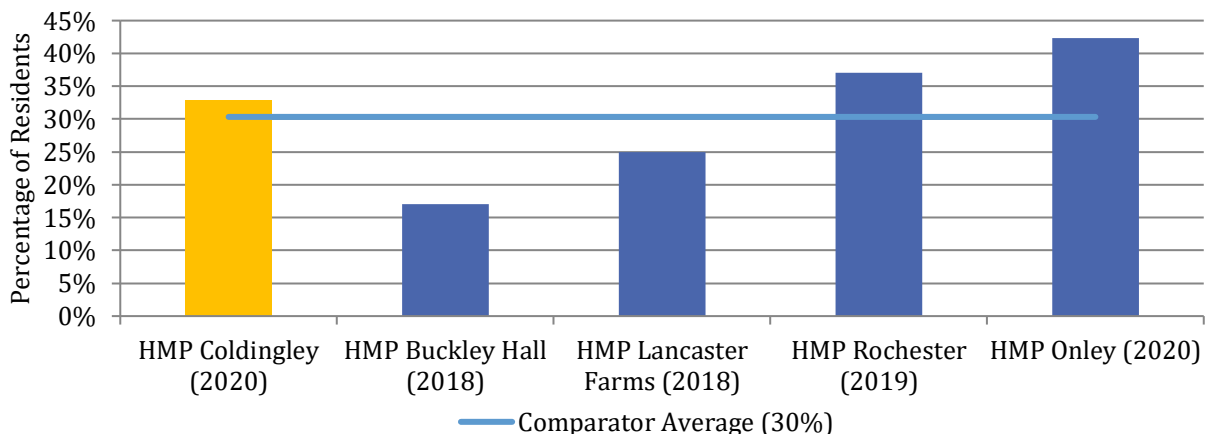
HMP Coldingley falls within Surrey County Council local authority area. There is a memorandum of understanding (MOU) in place between all five Surrey prisons, the council, and healthcare. Social care needs can be identified at any stage during a person’s stay, prompting a referral to the council. The prison, primary care, and the social care team feel this process works well, and social care described being one of the top performing authorities in prison social care. Surrey Council is CQC registered to provide the direct care itself. It feels that primary care often overlooked the non-physical care needs, e.g. ASD and LD. The full team for the whole of Surrey (all full-time) is an assistant team manager, two registered social workers, a senior social care assistant, four support time recovery workers (STRs) and an admin person. In our experience, this is a better level of staffing per capita than many other areas.

11.2 Social Care Needs

We were unable to obtain any relevant equalities data from HMP Coldingley so have had to rely on SystemOne data to explore possible areas of need in the prison. As with many other aspects of SystemOne recording, the read codes for social care needs can be confused and overlapping, making it difficult to gain a clear picture; this is a national issue outside local control.

SystemOne data at October 2020 describes 147 patients (33%) with a record of disability. This is slightly above average among the SystemOne reported rates for comparators.

Figure 99 – Patients With Recorded Disability (SystemOne data)



The table below shows the numbers of records on SystemOne of disability, mobility problems, or use of mobility aids (affecting five or more residents).

Figure 100 – Disability and Mobility Problems (SystemOne data)

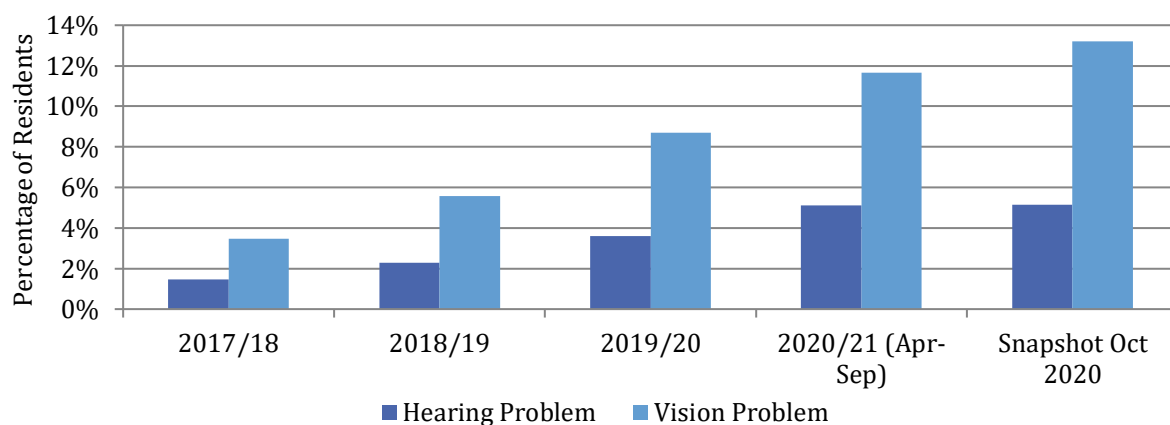
HMP Coldingley	Snapshot Oct 2020
Disability	107 (24%)
Physical disability	33 (7%)
Reduced/impaired mobility	22 (5%)
Difficulty writing	13 (3%)
Difficulty mobilising	13 (3%)
Disabled	11 (2%)
Patient reported disability	7 (2%)
Registered disabled	6 (1%)
Disability NOS	5 (1%)

In our patient survey, 13% (n=7) of respondents self-reported having a physical disability or mobility problem – a higher proportion than the average of 11% across four comparators (HMP Rochester, HMP Lancaster Farms, HMP Onley, and HMP Buckley Hall). There are at least two disabled cells at HMP Coldingley and several others that have various adjustments.

The chart below outlines the proportion of residents recorded on SystemOne with sensory impairments, in recent years and at a 2020 snapshot. The data describes a steady increase in the recorded prevalence of both vision and hearing problems. At snapshot, there were no patients with a recorded speech problem.

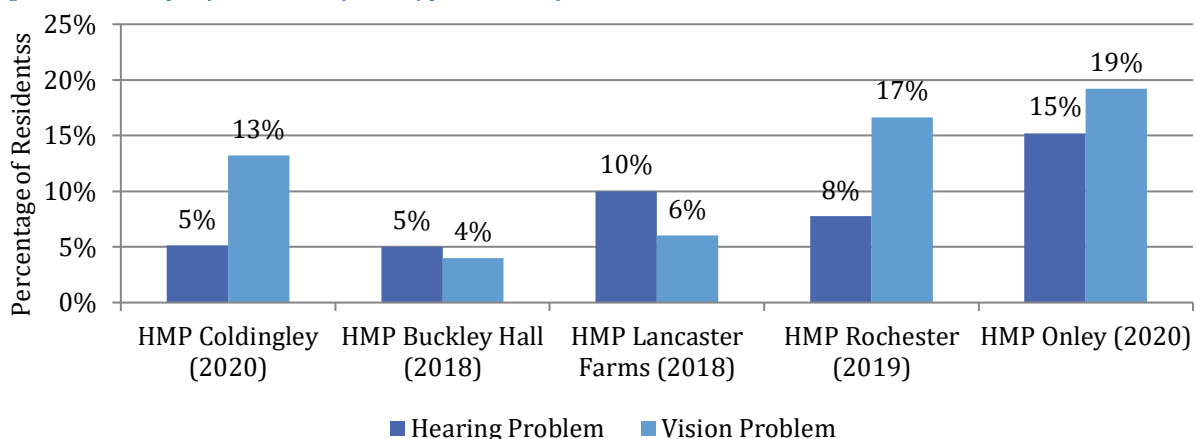
In our patient survey, 25% (n=13) of patients said they had a hearing or sight problem. This was a much higher proportion than the average of 10% across the four comparators with available data.

Figure 101 – Sensory Impairment (SystemOne data)



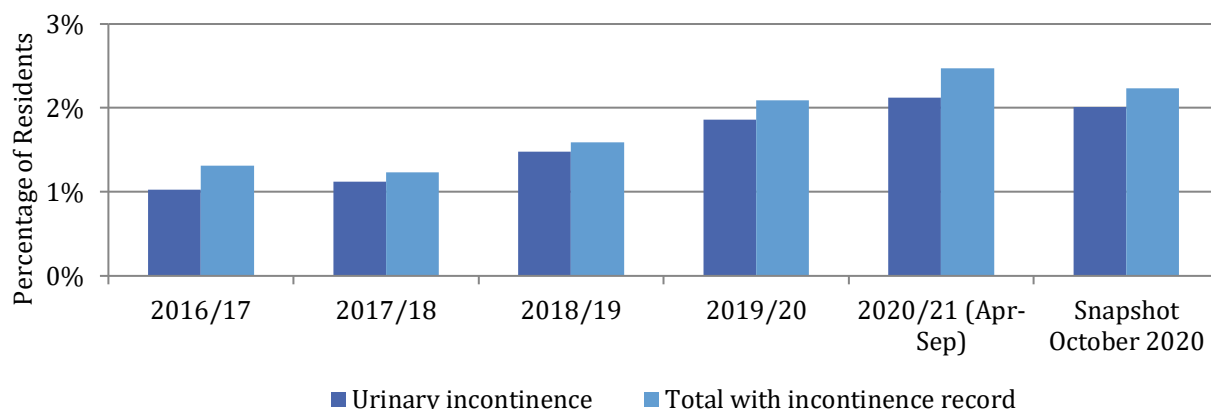
As a benchmark, the chart below shows the rate of identified sensory impairments at HMP Coldingley alongside comparators. HMP Coldingley has an average rate of identified vision problems (13%, n=59), but the rate of identified hearing problems (5%, n=23) is lower than most comparators.

Figure 102 – Sensory Impairments Comparison (SystemOne Data)



The chart below summarises SystemOne data on recorded continence problems at HMP Coldingley. Patients were mostly recorded as having urinary incontinence only, with fewer than five patients recorded each year with faecal incontinence, or double incontinence, over the past four years. At October 2020, there were 10 patients (2.2% of the population) with any continence problems recorded. This was higher than comparators (an average of 1.3% across the four comparator prisons). Note the lack of a sink or toilet in three-quarters of the cells.

Figure 103 – Continence Problems (SystemOne data)



The table below summarises self-care problems (only those recorded as affecting five or more residents) recorded on SystemOne at a recent snapshot.

Figure 104 – Self-Care Problems (SystemOne data)

HMP Coldingley	Snapshot Oct 2020
Unable to perform personal care activity	9 (1.6%)
Patient requires medication to be administered	8 (1.4%)
Needs help washing self	5 (0.9%)

We would not expect there to be many men with self-care problems in a working prison.

As can be seen there is a range of disabilities affecting a sizeable percentage of the population of HMP Coldingley, although few of these will require social care input.

11.3 Service Provision

Surrey County Council has responsibility for social care needs assessments at HMP Coldingley and the other Surrey prisons. Residents can self-refer by post, as can their families and any professional involved with them. Professionals refer by secure email or through Surrey's referral portal. In practice, most referrals are either self-referrals or from primary care. Social care reports that referrals are often poor (80% of them).

Social care has access to SystemOne and will look at the records to inform triage/assessment. SystemOne is not automatically updated but the care plan will be put on there once it has been agreed. If it is a resident self-referral they will be seen for screening and assessment. If the referral is from a professional, more information will be requested first. The social workers do the bulk of the on-site assessments, sometimes it might be the occupational therapist (OT) if that is clearly indicated in the referral. The senior assistant social worker covers HMP Coldingley. Some assessments do not lead to care plans but to one-off interventions such as signposting. Social care reports no problems getting into the prison to see people since covid-19.

In 2019/20 (i.e. pre-covid-19) there were 22 referrals from HMP Coldingley for social care, 10 of which were self-referrals. Twenty-two were assessed and eight considered appropriate for social care. The more common reasons were an equipment need and support with physical disabilities, although mental health/dementia, learning disabilities and autism were also established as needs. Social care works a lot with LD and ASD and liaises closely with CNWL's LD nurse, as well as wider mental health. There are good links around brain injury provision from Headway. The data supplied by the council was not informative as to what any of the specific packages of care involved.

The prison reports that social care needs have increased over time, There are mixed views within healthcare as to whether more social care resource is needed, although primary care reports that there is still not much social care needed, that the pathway is good and there are sufficient resources available to meet what need there is. There is good communication and staff try and make the social care staff feel part of the team. Social care feels generally embedded in the system at all levels, from strategic to operational, although this is undermined by not being able to access the council IT in the prison. Social care attends MAPPA and similar meetings, both in an organisational capacity and in regard to specific individuals.

If there is a need for equipment identified in the assessment and plan, social care will secure this (e.g. fall sensors, white sticks, special lighting). Substantive works (e.g. installing a ramp or rails) are usually the responsibility of the prison. Social care reports that it is usually possible to agree where respective responsibilities lie or what priorities are. It often accesses existing resources but also can and does buy in input as needed.

There was a 'buddy' system in place. This is now largely in abeyance, but will be relaunched post-covid-19. Social care recruits, trains and supervises the peer workers. The social care assistant team manager supervises them in groups fortnightly in each prison. These peer workers are for non-intimate and non-regulated care, e.g. help with cleaning the person's cell, getting meals, pushing a wheelchair, etc. At HMP Coldingley, they are called PACE workers (we couldn't establish what this was an acronym for).

Most of the peer work has stopped or considerably reduced because of covid-19, except for some exceptions where there is little or no alternative. In most cases the social care STR workers have picked up the slack, albeit with reduced and prioritised interventions.

11.4 Care Leavers

As described in Part B, there is an enduring responsibility placed on the care leaver's home children's service to support young adults leaving care. The issue for the prison is identifying these people and linking them to the responsible authority.

During 2019/20, there were fewer than five residents in HMP Coldingley recorded as being aged under 21, while 106 (12% of the population) were aged 21-24 years. As described in Part B, it is estimated that 40% of residents under the age of 21 will have been in care, and also a disproportionate number (at least 23%) of those aged 21-24 years. In our survey, 12% (n=6) of patients said they had previously been in care, average amongst recently surveyed comparators (an average of 14% across four comparators). Taking these figures, we estimate that during 2019/20, approximately 26 residents will have been care leavers probably eligible to leaving care support. There are also likely to be 10 current residents falling into this category. Social care will support care leavers in linking with the relevant local authority's care leavers team.

11.5 Release Planning

Social care is very involved in continuity of care as staff are aware that the person's needs may well not be met back in the community. They will liaise with the relevant local authority, wherever they are in the country. This doesn't always work well, but sometimes works very well, e.g. they have been able to line-up old people's homes and supported accommodation on occasions.

11.6 Chapter Summary

- There is a range of disabilities affecting a sizeable percentage of the population of HMP Coldingley, although few will require packages of social care.
- Surrey County Council has responsibility for social care assessment and provision at HMP Coldingley. Everyone feels the system works well. There is probably sufficient resource.
- Social care works with the full range of care needs, providing equipment, direct care and case management.
- Social care supported a well-run buddy system, currently in abeyance.
- OMU and social care will support care leavers as needed.
- Social care will support release planning for those with social care needs.

Chapter Twelve – Overview of Findings and Recommendations

12.1 Summary

This HSCNA has systematically explored the predicted needs, the actual identified needs, and the service provision of health and social care within HMP Coldingley. This has been through the lens of prevalence, incidence and, where possible, the likely demand for services. Current local data is compared to national data and to academic studies and to data sourced from a range of similar establishments. This is supplemented with qualitative work exploring pathways and stakeholder perspectives among patients, operational staff, managers and commissioners around actual service usage.

HMP Coldingley is a category C working prison with a mostly long-term population. Residents are usually there long enough that necessary screens and treatments should be possible. Many will be in custody a sufficient time to develop health conditions that will require attention during their period of custody. There was a consistent view amongst people we spoke to that, historically, the level of need at the prison had been underestimated and that therefore healthcare was insufficiently resourced to meet the need in most areas of provision. This was particularly acute where mental health was concerned. Services were nevertheless highly regarded. Healthcare has coped well with covid-19, although waiting lists have grown for some specialist services.

12.2 Chapter Summaries

This report is presented in two parts. This document is Part A which describes needs and provision in HMP Coldingley. Part B is a separate reference document detailing background information about a wide range of health and social care needs amongst residents.

[Chapter One](#) sets the context for prison healthcare and the rationale for the HSCNA. It also details the methodology used to combine qualitative and quantitative methods to achieve a balanced analysis of need.

[Chapter Two](#) outlines the demographic information from the prison, with a focus on those demographics that are known to affect the demand for aspects of healthcare. HMP Coldingley is a category C working prison. The operational capacity is 456, all housed in single cells. Two-thirds of cells do not have integral sanitation. Most residents are there long enough that necessary screens and treatments should be possible. Many will be in custody long enough to develop health conditions that will require attention.

[Chapter Three](#) gives an overview of the healthcare provision. Healthcare services at HMP Coldingley are generally well-regarded by staff and residents. Primary care is appropriately staffed and provided to meet the need, although some of the specialist in-reach provision needs to be increased. Covid-19 has been managed well and primary care delivery has continued, although large waits have developed for the in-reach services. Medicines management is good.

[Chapter Four](#) describes physical health, providing data on the predicted and identified health needs for key physical conditions, including long-term conditions (LTCs). Overall, identification and treatment for long-term conditions appears good, though there could be

room for improvement in monitoring and record-keeping. Increased oversight from a responsible lead LTC nurse is recommended.

[Chapter Five](#) covers mental health. What mental health provision there is, is well-regarded, but very limited by resource. The model needs review and appropriate resourcing if needs are to be met. There are several gaps in resourcing and provision, particularly for primary-level psychosocial support and interventions, and for longer-term specialist psychological interventions, e.g. for trauma and personality disorders. Psychology should be integrated with the wider mental health provision.

[Chapter Six](#) provides an overview of substance misuse needs. The substance use profile of the population in HMP Coldingley is different to the usual profile for training and resettlement prisons, with a lower proportion of substance misuse problems in general and a lower severity of types of substance use. The service is good at engaging people in treatment, particularly drinkers, and most needs appear to be identified and met. Provision has continued well under covid-19. The substance misuse strategy framework works well and there are effective partnerships.

[Chapter Seven](#) describes screening and vaccinations for communicable diseases. Discrepancies between different data sets, and inconsistencies in data collection and record-keeping, make it hard to assess whether need is being met. Overall, it appears that screens and vaccinations are being offered, but take up is low. Pathways where there are concerns are good, but more could be done to improve screening and take up of vaccinations. Vaccination resistance for covid-19 should be prepared for and addressed.

[Chapter Eight](#) covers national screening programmes. The physical health checks appear to largely be taking place as needed. Needs for AAA screening and diabetic retinopathy screening appear to be partially if not largely met. The need for bowel cancer screening is not fully met.

[Chapter Nine](#) provides a review of self-harm in the prison. Rates of self-harm are low and have been steadily reducing since 2017. The number of ACCTs is consistently low and these work well. The last self-inflicted death at the prison was in 2018.

[Chapter Ten](#) covers health promotion and wellbeing. Most survey respondents reported similar health prior to imprisonment. Primary care is active in health promotion across a range of topics. A multi-agency approach to healthy living would be beneficial. Roughly three-quarters of the population are overweight. Half the prison uses electronic cigarettes.

[Chapter Eleven](#) covers social care need and provision. There is a range of disabilities affecting a sizeable percentage of the population of HMP Coldingley, although few will require social care. Surrey County Council has responsibility for social care assessment and provision at HMP Coldingley. Everyone feels the system works well. There is probably sufficient resource. Social care supported a well-run buddy system, currently in abeyance.

[Chapter Twelve](#) provides this summary and recommendations

12.3 Findings and Recommendations

The following table summarises each finding alongside recommendations.

Figure 105 – Findings and Recommendations for HMP Coldingley

Section	Finding	Recommendation
Prison Demographics	There is a growing awareness of the needs of transgender residents.	Recommendation 1: Ensure transgender pathways are fit for purpose.
Physical Health	Covid-19 has shifted the healthcare delivery from being entirely centralised to being partially wing-based. There are advantages in both.	Recommendation 2: Review the overall healthcare delivery model as part of the recovery from covid-19.
	Emergency codes recorded on SystmOne are different than published numbers.	Recommendation 3: Ensure consistent recording of emergency codes on SystmOne.
	The 'extra' weekly dental session is needed to keep waits within acceptable limits. Optional extra sessions will be needed to clear the covid-19 backlog and to keep waits within acceptable limits.	Recommendation 4: Increase the commissioned dental provision to at least three sessions per week, with optional extra sessions to limit waiting lists appropriately.
	Physiotherapy sessions need to be increased to meet need, and extra sessions will be needed to clear any backlog arising from covid-19.	Recommendation 5: Increase the physiotherapy sessions to two per week, along with temporary extra sessions to help clear any backlog.
	The podiatry provision is insufficient to meet the need.	Recommendation 6: Review the podiatry provision for HMP Coldingley.
	Some podiatry education and training for primary care may help improve diabetes care.	Recommendation 7: Develop podiatry education and training across the Surrey prisons.
	The analgesic review clinics have helped bring down the use and misuse of tradable medicines.	Recommendation 8: Embed the analgesic review clinics into the healthcare provision in all the Surrey prisons.
	More non-medical approaches to pain control and sleep will help further reduce the use of tradable drugs.	Recommendation 9: Further develop non-medical approaches to pain-management and sleep.
	The LTCs would benefit from review of treatment plans and oversight of care and monitoring.	Recommendation 10: Develop lead responsibility for oversight of long-term conditions.
	Mental Health	The mental health provision is very small and targeted on secondary mental health. There is a range of unmet mental health needs.
Psychology is a separate team from mental health.		Recommendation 12: Fully integrate psychology into the mental health team.
There are no band 5 or 6 RMNs in the mental health team.		Recommendation 13: Increase the mental health nursing provision.
Psychology provision is insufficient to meet the need.		Recommendation 14: Increase the provision for tier 2 and tier 4 interventions.
There are limited resources for psychosocial responses to primary mental health concerns and very limited resources for longer-term counselling.		Recommendation 15: Further develop pathways for psychosocial responses to primary mental health needs and resource these accordingly, including for longer-term emotional support and counselling.
Identified prevalence of depression is below predicted prevalence and below comparators.		Recommendation 16: Mental health and patients to explore depression pathways and provision, to inform improved identification and response.

Section	Finding	Recommendation
	The psychology resource is insufficient to address the need for interventions for personality disorder.	Recommendation 17: Review personality disorder pathways and resources so more of the need can be addressed.
	There are insufficient resources to address the long-term impacts of trauma.	Recommendation 18: Further resources to be developed to support trauma-focused interventions.
	Several staff reported the adverse impact of the neighbouring firing range on some residents.	Recommendation 19: Consider which cases of PTSD can be placed at HMP Coldingley.
	LD identification is good but there is insufficient resource to fully meet the direct need and a need for training for staff.	Recommendation 20: Develop the LD pathways and support for other staff.
	Autism pathways need developing and there is insufficient resource to fully meet the direct need, as well as a need for training for staff.	Recommendation 21: Further develop multidisciplinary autism pathways and resource.
	Dual diagnosis pathways could be improved with common record keeping.	Recommendation 22: Forward Trust to ensure full records on SystemOne.
Substance Misuse	Trauma issues often underlie and drive substance misuse and may require longer-term interventions to address.	Recommendation 23: Develop pathways for longer-term therapeutic interventions for substance misusers.
	Most OST patients are 'maintained', rather than 'reducing'.	Recommendation 24: Further develop a focus on OST reduction, cessation, and recovery.
	Levels of engagement with community services on release are well below national averages.	Recommendation 25: Increase engagement with community provision on release.
Communicable Diseases	Rates of BBV screening and HBV vaccination are below the average for trainees nationally and show a large drop-off, particularly to the endpoint.	Recommendation 26: Primary care and SMS to work together to support increased testing for BBV and take up of HBV vaccination, adopting MECC (making every contact count) principles and ensuring accurate record keeping.
	Anecdotally, it appears that some residents are considering refusing any covid-19 vaccine.	Recommendation 27: Ensure maximum take up of any covid-19 vaccine.
Health Promotion	More could be done to promote healthy living across the prison, particularly as lockdown ends.	Recommendation 28: Establish a multi-agency group to support health promotion and healthy living.
	Half the prison currently uses electronic cigarettes.	Recommendation 29: Promote reduction and cessation of vaping.

APPENDIX A – List of Interviewees

Figure 106 – List of Interviewees

Name	Job Title	Organisation
Julia Fraser	Senior Commissioning Manager	NHS Health and Justice, NHS England and NHS Improvement (South East England)
Debra Chamberlain	Head of Healthcare	CNWL
Dr Hannah Bryant	Lead GP	Medco
James Adamson	Head of Drug Strategy and Healthcare Provision (outgoing)	HMP Coldingley
Elen Parry	Head of Drug Strategy and Healthcare Provision (incoming)	HMP Coldingley
Dean Sinclair	Safer Custody (outgoing), Head of Offender Management Services (incoming)	HMP Coldingley
Di Close	Head of Offender Management Services (outgoing)	HMP Coldingley
Carol Casbierd	Primary Care Lead	CNWL
Leanna Challen	Service Manager	Forward Trust
Helen Spencer-Hicks	Mental Health Service Lead	CNWL
Caroline Hewlett	Senior Manager (Specialist Services, EIS, EHIP, Older People Mental Health & Prison Social Care)	Surrey County Council
Donna Lander	Assistant Team Manager	Surrey County Council
Khurshid Choudhry	Lead Pharmacist	CNWL
Amir Vahdat	Dentist	Tooth and Mouth
Sarah Buckland	Physiotherapist	First Community Health and Care
Tom MacDonald	Optician	Superspecs
Julia Windheuser	Podiatrist	First Community Health and Care
Stephen Haynes	Learning Disability Nurse	CNWL
John Burns	Consultant Clinical Psychologist and Lead Psychologist for Surrey Prisons	CNWL
Kelly Zerrouk	Learning, Skills and Employment Manager	HMP Coldingley
Lloyd Kristian	Regional Operations Manager, Surrey Prisons.	CNWL
Kristian Lane	Lead Nurse for Offender Care	CNWL
Steven Turner	Surrey Prisons Performance Lead	CNWL
Donna Gipson	Engagement and Operations Lead	EP: IC
Written Information:		
Dave Lewis	Head of Security	HMP Coldingley

There was also an initial presentation and workshop involving the governing governor, the outgoing and incoming governors responsible for healthcare and drug strategy, the head of healthcare, and the mental health lead.

In addition, a survey was distributed across the prison and 52 patients returned comments. We also had access to the reports from the user surveys carried out by EP: IC.

APPENDIX B – Long-Term Condition Management

Figure 107 – Full Data for Selected QOF Indicators

Condition	Indicator	Percentage of Eligible Complete	Complete	Eligible
Asthma	Review in previous 12 months	0%	0	41
COPD	Review/assessment in last 12 months	0%	0	<5
	Influenza immunisation in last winter	100%	<5	<5
Cancer	Review within 6m of diagnosis	100%	<5	<5
Diabetes	Blood pressure checked + in optimal range	36%	5	14
	Foot examination in last 12 months	18%	<5	17
	IFCC-HbA1c checked + in optimal range	63%	12	19
	Treated with a statin	69%	11	16
	Influenza immunisation in last winter	56%	5	9
CHD	Blood pressure checked + in optimal range	45%	5	11
	CHD therapy in last 12 months	70%	7	10
	Influenza immunisation in last winter	25%	<5	8

Figure 108 – Definitions of QOF Indicator Values from 'How Am I Driving', used in Chapter Four

Indicator	Explanation
Asthma - review in previous 12 months	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the three Royal College of Physicians (RCP) questions.
COPD - review/assessment in last 12 months	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, in the preceding 12 months.
COPD - influenza immunisation in last winter	The percentage of patients with COPD, on the register, who have had influenza immunisation in the preceding 1 August to 31 March.
Cancer - review within 6m of diagnosis	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis.
Diabetes - blood pressure checked + in optimal range	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less
Diabetes - foot examination in last 12 months	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months.
Diabetes - IFCC-HbA1c checked + in optimal range	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c reading (measured in the preceding 12 months) is 58mmol/mol or less, or is 75mmol/mol or less, depending on patient eligibility.
Diabetes - treated with a statin	The percentage of patients with diabetes, on the register, either aged 40 years and over, no CVD, on statins, or history of CVD, currently treated with a statin.
Diabetes - influenza immunisation in last winter	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March.
CHD - blood pressure checked + in optimal range	The percentage of patients with CHD, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less.
CHD - CHD therapy in last 12 months	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.
CHD - influenza immunisation in last winter	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March.

APPENDIX C – Predicted Substance Use Incidence Calculations

Figure 109 – Calculation of Predicted Need

Drug Treatment	HMP Coldingley
Population in a year (op cap + turnover)	928
Prevalence estimate (low)	28%
Prevalence estimate (high)	51%
Expected incidence (low)	260
Expected incidence (high)	473
Expected incidence (mid-point)	367
Alcohol Treatment	HMP Coldingley
Population in a year (op cap + turnover)	928
Prevalence estimate (low)	16%
Prevalence estimate (high)	43%
Expected incidence (low)	148
Expected incidence (high)	399
Expected incidence (mid-point)	274

APPENDIX D – Full NDTMS Data

Section 1: New Treatment Entrants	2019/20		
	HMP Coldingley	Training Prisons on Average	National Average
Number of new receptions starting new treatment episode	162	12348	54965
Percentage of new receptions to prison who enter drug treatment	50%	30%	31%
Total new treatment entrants (includes those who are not new receptions to the prison)	201	14392	58903
New treatment entrants from within prison	39	2044	3938
Percentage of new treatment entrants from population already in the prison	19%	14%	7%
Opiates	65	7317	34415
Non-opiates	60	3264	9891
Non-opiates and alcohol	63	2643	8807
Alcohol only	13	1168	5790
Opiates	32%	51%	58%
Non-opiates	30%	23%	17%
Non-opiates and alcohol	31%	18%	15%
Alcohol only	6%	8%	10%
Modalities started YTD	No.	Prison %	Training Prisons %
Total interventions started	289		23252
Alcohol prescribing	0	0%	203
Benzodiazepine detox	0	0%	19
Lofexidine	0	0%	0
Naltrexone pre-release	0	0%	19
Opioid reinduction	0	0%	35
Opioid reduction methadone	17	6%	1571
Opioid reduction buprenorphine	0	0%	64
Opioid maintenance methadone	36	12%	4528
Opioid maintenance buprenorphine	2	1%	212
Alcohol brief intervention (unstructured)	0	0%	1737
Other formal psychosocial therapy	93	32%	5366
Other structured intervention	109	38%	8719
Psychosocial intervention for mental disorder	0	0%	116
Structured day programme	32	11%	663

Section 2: In-Treatment Population	2019/20		
	HMP Coldingley	Training Prisons on Average	National Average
Total number in treatment	258	23240	80183
Opiates	86	11921	45447
Non-opiates	78	5192	14312
Non-opiates and alcohol	75	4275	12648
Alcohol only	19	1852	7776
Opiates	33%	51%	57%
Non-opiates	30%	22%	18%
Non-opiates and alcohol	29%	18%	16%
Alcohol only	7%	8%	10%
Interventions - number in...			
Clinical only	0	663	5704
Non-clinical structured intervention only	205	13638	35594
Clinical and non-clinical structured interventions	53	8487	38202
No structured modality started/recorded	0	452	683
Clinical only	0%	3%	7%
Non-clinical structured intervention only	79%	59%	44%
Clinical and non-clinical structured interventions	21%	37%	48%
No structured modality started/recorded	0%	2%	1%
Interventions ended			
Number of interventions ended	248		
Average intervention length (days)	101	156	93
Characteristics of those in treatment during period			
AUDIT score: 0-7	149	% 8+ (prison):	National:
AUDIT score: 8-15	23	42%	42%
AUDIT score: 16-19	27	% 20+ (prison):	National:
AUDIT score: 20-40	59	23%	31%
AUDIT score: missing data	0		
NPS main drug	21		3,412
NPS second drug	5		1,678
NPS third drug	6		1,987
Total in treatment citing NPS use (drug use recorded at treatment start)	32		7,077
% of in-treatment population citing NPS use	12%		9%
% reporting primary NPS use	8%		4%